# Maternal and Child Health Services
# Title V Block Grant

# State Narrative for Virgin Islands

## Application for 2010
## Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

# Table of Contents

# I. General Requirements

## A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
***An attachment is included in this section.***

## B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

## C. Assurances and Certifications

By submission of the Title V Block Grant (BG) Application for 2009-2010, the Virgin Islands Department of Health (VIDOH) assures compliance with all requirements established by OBRA'89 (PL 104-193, 1996). Funds allotted to VI will only be used for addressing the identified needs of women, infants, children and adolescents, including those with special needs and their families; and for the proper management and implementation of the action plan as described in the application. The allotted funds will be fairly distributed across all MCH population groups in accordance to the mandate (30-30-10). These funds will be used only to carry out the purpose of Title V programs and activities, consistent with Section 508.

Under no circumstance will Title V Block Grant funds will be used for construction or the purchase of land.

Additionally, we certify that services will be rendered in a smoke-free environment, to provide a drug-free workplace in accordance with 45 CFR Part 76, and to comply with the prohibition of using federal funds to support any activity regarding lobbying or its appearance to.

Signed copies of the Assurances and Certifications required for this application are located at the MCH & CSHCN Program Administrative Office located on St. Thomas, VI.

These forms are available upon request by USPS Express Mail service.

## D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

## E. Public Input

The Virgin Islands Department of Health invites public review and input relative to planning for and writing the Title V Five-Year Block Grant Application and Program Plan for the Maternal Child Health & Children With Special Health Care Needs (MCH & CSHCN) Program. Notices are printed in local newspapers and aired on cable television public service announcements on both islands annually providing information on availability of the block grant application for public review and comment. Copies of the grant application are also available upon request to agencies and partners. Response forms accompany each copy with options to accept the application as written or accept with changes and / or additions.
Members of the MCH Advisory Council which includes parents, consumers and individuals from several public and non-profit agencies reviewed and endorsed the application prior to submission.

/2009/ Public input will be solicited this year by placing the application in selected community partner agencies, with a special focus on those who provide advocacy and outreach services to children with special health care needs and their families. //2009//

***/2010/ Public input into the Block Grant Application is an on-going process. In addition to review by members of the VI Alliance for Primary Care, and the MCH Advisory Council, individuals from several other agencies and organizations requested copies of the document this past fiscal year. Comments and suggestions included: strengthening children's mental health services with inclusion of discussion on addressing the issue of autism spectrum disorders; providing summary reports of the application to organizations that serve women and children; and have more public information on the program and the services offered. It is anticipated that the application will be available for review on the DOH website with feedback forms available by January 2010. Notices will be printed in the local newspapers and the application will be available at several sites and agencies. //2010//***

# II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

## C. Needs Assessment Summary

The Virgin Islands Department of Health continues to operate within the framework of Healthy People 2010, as its adoption is being implemented under The Virgin Islands Healthy People 2010: Improving Health for All, a Territorial departmental plan that provides focused areas for all departments' performance and improvement by the Year 2010. For the MCH & CSHCN Program in the U.S. Virgin Islands, Allocation of Resources and Evaluation is pivotal issues addressed in the needs assessment process and its links to Healthy People 2010. We identified present challenges as well as strengths in the MCH & CSHCN healthcare service delivery system. Achieving a system of care means, under the Five-year Plan - FY 2005-2010, providing the mechanism for improved coordination and collaboration of services for all segments of the target population served under MCH pyramid level of services.

***/2010/ The Department of Health debuted their new theme "Wellness is our way of life" capturing the need for continuous improvement in the rendering of services and in the quality of care. Moving towards the 2010 needs assessment, although strategically planned, has not been without challenges. The survey instruments have been drafted and sent out for review by participating members of the VI Alliance for Primary Care. With the compiled feedback, we intend on improving both assessment instruments to maximize the validity and reliability of these tools. //2010//***

Currently, the Program must re-group and re-engage collaborators and stakeholders, as a shift has occurred in the level of involvement collaborators, who were affected by the newly elected and/or appointed Executive Branch of the U.S. Virgin Islands Government. As part of this effort, the Data Committee, within the VI Alliance for Primary Care, will be re-activated and charged with the task of spearheading efforts to allocate resources critical to all Priority objectives linked to Healthy People 2010. The Committee will address Infrastructure Building Services as a high priority and as it pertains to improved electronic data collection and analysis to support ongoing programs and planning efforts of the agency. Dedicated partners from our local hospitals, private doctors and other private sector providers of health services, other government agencies and community based organizations are integral to this process and will have a specific roles, i.e., client satisfaction surveys, population-based data collection, input on CQI (Continuous Quality Improvement) process in support of this effort.

***/2010/ The Continuous Quality Improvement (CQI) team continues to work together on both program improvements as well as collaboratively on the analysis of the survey instruments and the collection and review of existing data. The program has been able to hold 3 Territorial meetings thus far with the CQI team. The team is comprised of administrative and clinical personnel, with the aim of impacting and effectuating the needs assessment action plan and process. //2010//***

A system of care is achievable as we have brought to the forefront and are addressing major issues, i.e., the need for focused adolescent health care services; comprehensive support services for children and families of children with special health care needs; healthy birth outcomes for all pregnant women, especially of low income, and decreased health disparities in segments of the population. MCH Program Administrator working in concert with practitioners and Advisory Council members will receive a full orientation on the Five-Year Plan. Work groups comprised of the individuals in these categories will be formed to assume responsibility for segments of the Plan and a recording and reporting system will be used to monitor and evaluate

progress.

MCH/CSHCN Advisory Board and Administrators continue to advocate for Adolescents access to a basic level of health care. The discussions and strategic planning are focused on how and where to provide confidential, appropriate care for their adolescents. Our contribution to this process is to engage Providers through surveys on the best practices to address the concerns of their adolescent patients and ways to guide their development as independent agents with regard to their health. Specifically, providers are being asked to assess the individual adolescent's developmental readiness, and to assist youth in making the transition between pediatric and adult care. Service providers will play an integral role in the coordination of the comprehensive services that influence the health behaviors of adolescents. Moreover, providers will understand and facilitate entry to specialized services for those adolescents who require them. For those services that are specialized, mechanisms will exist to assist adolescents to pay for and obtain necessary care from multiple sites and providers.

Broader commitment is being sought from local educational institutions and civic organizations serving youth and their families. These community supporters are needed to begin the dialogue with the young people and their caregivers on their perception of quality care, improved health options, well-being into adulthood for adolescents. Availability is another high point of concern as the need for age-appropriate services, access to location of services and hours of operation, and trained health care providers are all areas that are currently deficient in our community. Aligned with this is the issue of flexibility in services, providers, and delivery sites, as there must be consideration for the cultural, ethnic, and social diversity among adolescents. Source: Society for Adolescent Medicine, "Position Statements and Resolutions".
***/2010/ The program has made great effort this year in amassing a wide range of contacts in the pursuit of establishing and maintaining collaborative efforts with other agencies the provide services to adolescents. These agencies include the Department of Human Services, the Department of Education, Department of Health HIV/AIDS Program, the Department of Justice, the Police Department and various non-profits. //2010//***

See full summary in Attachment to this section.

***An attachment is included in this section.***

# III. State Overview

## A. Overview

III. STATE OVERVIEW

A. Overview

The Maternal and Child Health Block Grant is authorized by Title V of the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239. The Block Grant Funds assist the Virgin Islands in maintaining and strengthening its efforts to improve the health of all mothers, infants, and children, including children with special health care needs. The U.S. Virgin Islands Department of Health is the official Title V agency for the Virgin Islands.

The political status of the U.S. Virgin Islands, often called the "American Paradise", is that of an unincorporated territory. Residents are citizens of the United States. They elect the Governor, a non-voting Delegate to Congress, and a fifteen member Legislature.

Geography: The Territory of the U.S. Virgin Islands (VI) is a collection of four major islands-St. Croix, St. Thomas, St. John, Water Island, and approximately 50 small, mostly uninhabited islands. The location of the Territory is in the Caribbean Sea at the eastern end of the Greater Antilles and the northern end of the Lesser Antilles. The Territory is 1,600 miles south southeast of New York; 1,100 miles east southeast of Miami; and 100 miles southeast of San Juan.
Of the many islands and cays comprising the U.S. Virgin Islands, only four are of economic or clinical significance at the present time. The largest, St. Croix, is 82.9 square miles, mostly flat and therefore, the most suitable for intensive economic development. It has two main towns-Christiansted, the larger of the two on the east, and Frederiksted, the smaller and more depressed on the west.

Forty miles due north, St. Thomas is approximately 32 square miles and has rugged mountains that rise sharply from the sea to heights of up to 1,500 square feet. The population density is 1,543.8 persons per square mile, more than twice that of St. Croix. A few miles east of St. Thomas lies St. John, offering a similar land and seascape. More than half of the island is designated as a National Park, which has served to preserved much of this island's natural beauty. The main town of Cruz Bay is centrally located. The fourth isle is Water Island, transferred from the Department of Interior on December 12, 1996. The size of the island is 2-1/2 miles long and 2 miles wide with an area of 500 acres. Water Island is separated from St. Thomas by 2 mile and is close enough to draw life support from.

Population: According to the 2004 VI Community Survey (VICS), the population of the Virgin Islands was 111,459 persons: 54,626 on St. Croix, and 56,830 on St. Thomas/St. John. This is a 3% increase from the 2000 U.S. Census population of 108,612. The 2004 VICS data estimated males represented 47% or 52,402 and females 53% or 59,057. The median age of respondents was 37.2 years.
/2009/ According to the 2005 VICS, the population was 111,470 persons: 54,635 on St. Croix and 56,835 on St. Thomas/St. John. This represents a less than 1% increase from 2004 and a 3% increase from the 2000 U.S. Census population of 108,612. The survey data estimated males represented 47% or 52,052 and females 53% or 59,418. The median age of respondents was 38.4 years. Source: 2005 VI Household Income & Expenditure Survey, Eastern Caribbean Center, University of the Virgin Islands (EC Center, UVI). //2009//
***/2010/ The 2006 VICS shows a slight increase (1.2%) in the population to 113,689 persons; 55,722 on St. Croix and 57,967 on St. Thomas/St. John. This represents a 4.5% increase from the 2000 U.S. Census population of 108,612. Males and females remain consistent at 47% (53,513) and 53% (60,176) respectively. The median age of respondents was 39.9 years. Source: 2006 VICS, EC Center, UVI. //2010//***

Population less than 19 years: Children and youth 0 -19 years represent 31.2% of the population or 34,817.

/2007/ In 2004, there was a decrease (6.6%) in children under age 5, and children ages 5-9 and 10-14 had slight decreases (1.3%) in this reporting year. Adolescents (teens) 15-19 had a .3% increase or 8,821 compared to 2003 (8,494). (Source: 2004 VICS, EC Center, UVI; 2000 VI Population Census, U.S. Census Bureau)//2007//
/2009/ In 2005 children and youth 0 -- 19 years represented 31% of the population or 34,556. A slight increase is noted to 7.1% ( 7,937 from 7,371 in 2004) in children under age 5. Children ages 5-9 show a decrease of 1.2% (7,866 from 9,016 in 2004) and a slight increase in ages 10-14 of 0.3% ( 10,002 from 9,609 in 2004). Adolescents (teens) ages 15-19 also had a slight decrease of 0.1% (8,751 from 8,821 in 2004). //2009//
***/2010/ In 2006, children and youth 0 -- 19 years represented 27.5% of the population or 31,231, a decrease from 31% (34,556) in 2005. A decrease of 6% is noted in children under age 5 from 7,937 (or 7.1%) in 2005 to 6,823 in 2006. Children ages 5-9 show a decrease of slightly less than 1% (7,866 in 2005 to 7,130 in 2006), and a 1.2% decrease in ages 10-14 (10,002 in 2005 to 8,744 in 2006). Adolescents (teens) ages 15-19 also had a slight decrease of 0.3% (8,751 in 2005 to 8,534 in 2006). //2010//***

| Age Group | 2006 | % | 2005 | % | 2004 | % | 2003 | % | 2000 | % |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 5 years | 6,823 | 6.0 | 7,937 | 7.1 | 7,371 | 6.6 | 8,188 | 7.4 | 8,553 | 7.9 |
| 5-9 years | 7,130 | 6.3 | 7,866 | 7.0 | 9,016 | 8.1 | 9,144 | 8.3 | 10,176 | 9.4 |
| 10-14 years | 8,744 | 7.7 | 10,002 | 8.9 | 9,609 | 8.6 | 10,232 | 9.3 | 9,676 | 8.9 |
| 15 -- 19 years | 8,534 | 7.5 | 8,751 | 7.8 | 8,821 | 7.9 | 8,494 | 7.6 | 6,688 | 8.0 |

Population by Age and by Percentage: /2007/ A slight increase occurred in the VI population according to the 2004 VICS conducted by the EC Center, University of the Virgin Islands. The survey shows a 9.5% increase from 101,809 in 1990 to 111,459 in 2004. While the overall population increased, a slight decrease of 1.8% occurred in the 0-5 years population in the same period. However, the category of ages 5-19 years showed an increase of 4.9% to 34,817. Table 1-B shows the comparison for the period 1990-2004. (Source: 2004 VICS, EC Center, UVI; 2000 VI Population Census, U.S. Census Bureau) //2007// (Please refer to Table 1-A: 2000 VI Census Total Population by Age and Table 1- B: Population by Percentage under Appendices/State Support Documents.)
***/2010/ The overall VI population increased 10.5% in the period 1990-2006 (101,809 to 113,689), with a slight decrease ( 6.9%) evident in the 0 -- 19 age groups. Concurrently, the 20- 59 and 60+ age groups showed a total increase of 17.4%. //2010//***

Population by Race/Ethnic Composition: The entire VI population consists of persons who are predominantly of African descent, Black or African-American. While St. Thomas has the highest percentage of people of African descent, St. Croix has the highest percentage of Hispanics, whose place of origin may be other Spanish-speaking islands, such as Puerto Rico or the Dominican Republic. The 2000 Census estimated the racial composition of the V.I. population as Black/African American 76.2%, Whites 13.1 %, Other Races 7.2% and two or more races 3.5%. (Please see Table 2: 2000 VI Census Population by Race under Appendices/State Support Documents.)
/2007/According to the 2004 VICS, a slight decrease occurred in both the Black/African-American (0.4%) and White (0.8%) populations. A slight increase was reported in Other Races (1.8%). (Source: 2004 VICS, EC Center, UVI) //2007// (Please see Table 2-A: 2003-2004 USVI Population by Race under Appendices/State Support Documents.)
***/2010/ 2006 data shows slight population decreases in the Black/African-American population at 89,659 or 78.9%, and Whites at 9,044 or 7.9%. A moderate increase in other races to 14,986 or 13.2% is noted. //2010//***

Persons of Hispanic or Latino Origin. The 2000 Census estimated 93,416 persons of non-Hispanic origin and 15,196 persons of Hispanic origin (Table 3). The majority of Hispanic residents reside on St. Croix with an estimated population of 11,277. (Source: 2000 VI Population Census, U.S. Census Bureau) (Please see Table 3: 2000 USVI Census by Hispanic or Latino origin under Appendices/State Support Documents.)
/2007/ The 2004 VICS estimated 89,185 (80%) persons of non-Hispanic origin and 22,274 (20%) persons of Hispanic origin reside in the Territory. The majority, 14,311 (12.8%) reside on St. Croix. (Source: 2004 VICS, EC Center, UVI) //2007// (Please see Table 3-A: 2004 VICS Population by Hispanic Origin under Appendices/State Support Documents.)
***/2010/ Total Hispanics or Latinos in 2006 were reported at 20,836, a decrease (1.3%) from 22,274 in 2004. The age group 0 -- 19 years accounts for 6,648 persons or 32% of Hispanic/Latino origin and 5.8% of the non-Hispanic population. The majority, 14,760 or 13%, reside on St. Croix. //2010//***

Population by Nativity/Citizenship: The VI is a multicultural society. The 2000 U.S. Census shows approximately 66.8 % of the population was born in the VI and 33.2 % born outside of the Territory. In 1995, approximately 50.5% of the population was born in the VI and 49.5% were born outside of the Territory according to the 1995 Population and Household Survey. Table 4 shows 21.2% are naturalized citizens, of which 3% entered from 1990 to 2000 and 18.2% entered before 1990. Many of the persons who migrated to the territory seeking employment have now established citizenship here. However, 2003 data shows a decrease in the population born in the VI (52,224 or 47%) and other U.S. born outside the Territory (16, 693 or 15%). This is a comparison for the period 2000-2003 by place of birth. Concurrently, there is a 3.5% increase in the number of naturalized citizens and slight increase (0.5%) in non-U.S. citizens who are permanent residents. Recently released 2004 preliminary data did not include nativity and not a citizen. The program will update this data as soon as it becomes available. (Please see Table 4: 2000 USVI Census Population by Nativity/Citizenship under Appendices/State Support Documents.)

Population by Place of Birth: /2007/The 2004 VICS shows a continued decrease in the population born in the VI (50,643 or 45%). In comparison to the same period last year, the population by place of birth shows a decrease in other U.S. born (12,552 or 11.2%, and a slight increase in Other Caribbean born to 38,905 or 34.9%). (Source: 2004 VICS, EC Center, UVI) //2007// (Please see Table 4-A 2003 Population by Place of Birth under Appendices/State Support Documents.)
***/2010/ There is a slight increase in the native/US born population. This may be attributed in some part to the increase of undocumented women who migrate to the territory to ensure citizenship for their offspring. //2010//***

Per Capita Income: In 2002, the per capita income in households in the VI was $14,370. St. John had the highest per capita income of $19,394, followed by St. Thomas at $11,776 and St. Croix's at $9,402. In 2001, per capita income in households was $13,885. Per capita income in households on St. John remained highest at $17,282, followed by St. Thomas at $14,318 and St. Croix at $13,197. (Source: V.I. Bureau of Economic Research (VIBER)- August 2005)
/2007/ Per capita personal income in the Territory was reported at $17,581 in 2003 and $18,108, in 2004. Household per capita income is not available for those years. (Source: VIBER- August 2005) //2007//
/2008/ Per capita personal income is reported at $18,652 in 2005. Annual average gross pay for the same period is reported at #33,384. (Source: VIBER- April 2007) //2008//
/2009/ Per capita personal income for 2007 is reported at $19,787. Annual average gross pay for the same period is reported at $36,510. Household per capita income is not available. (Source: VIBER. December 2007) //2009//
***/2010/ Per capita personal income for 2008 is estimated to be approximately $20,380, about 50% of the US per capita PI average. Annual average gross pay for the same period is reported at 36,992. //2010//***

Poverty Status: Based on 1995 VI Population and Household Survey, 20.6% of families had incomes in 1994 below poverty levels. Poverty levels increased in 1999 for families to 28.7%. For individuals, 32.5% had incomes below poverty. Though poverty levels decreased for families, in 2001 child poverty in the VI continues to be high with a rate of 36.5%. Children living on St. Croix have a significantly higher rate of poverty rate at 45%, when compared to St. Thomas at 31%. Children on St. John have a lower rate of poverty at 10.5%. The national child poverty rate in 2001 was 16%. The 2002 poverty level for families was reported at 22.2%. For individuals or persons, the poverty level was reported at 25.6%. (Source: USVI Kids Count Data Book 2003, Community Foundation of the Virgin Islands (CFVI))
/2007/ In 2003, the overall individual poverty rate increased, from 22.7% to 25.6% for the USVI as a whole. The rate of individual poverty was 30.4% on St. Croix, 25% on St. John, and 20.7% on St. Thomas. Family poverty rates increased to 22.2% in 2003, from 18.1% in 2002. Single parent families account for over 50% of all families in poverty and have a 66% higher risk of being poor. Child poverty increased in 2003 by 1.7% over 2002, from 30.6% to 32.3%. (Source: V.I. Kids Count 2005, CFVI) //2007//
/2008/The trend of child poverty in the VI has not improved. The child poverty rate reached 35.1% in 2004, meaning that more than one in three children lived below the poverty threshold. This rate is a 2.8% point increase from 2003, and a 5.5% point increase from 2002. The number of VI children in 2004 who were classified as poor under poverty guidelines grew to 11,114. In comparison, the US national child poverty rate remained constant at 18%. The rate of poverty in the VI exceeds the 31% rate of Mississippi. Poverty is the single greatest threat to the well-being of children in the VI. Growing up in poverty affects every area of a child's development -- social, behavioral, educational, as well as their health and living wage work potential. In addition to lost productivity, expenses are incurred by the general public for their social maintenance in health, welfare and criminal justice costs. //2008// (Source: VI Kids Count Data Book 2006 -- CFVI)
/2009/ One third (35.8%) of all VI children are growing up in households with incomes below the poverty threshold, one out of every three children. Despite a decreasing child population and fewer children living below the poverty rate, the trend of child poverty in the VI continued to rise in 2005. The number of the territory's children in 2005 who were classified as poor under federal poverty guidelines was 11,054 (a slight decrease from the 11,114 VI children in poverty in 2004). Children from birth to five years old are most vulnerable developmentally to poverty's impacts -- yet this age group has the highest rate of child poverty. The risk of a child being (and remaining) poor is significantly raised if the child has a single parent, if the parent has low wage-earning capacity or is unemployed, if a child underachieves or fails in school, and if he or she becomes a teen parent. Decades of research shows that young children raised in poverty have experienced more limited early care and education, enter school already behind other children, have lower academic performance in later years, and are more likely to drop out of high school. As adults in the job marketplace, they are almost twice as likely to be unemployed. Children raised in poverty are also more likely than their peers to suffer from health problems; asthma and malnutrition are examples. Ill-health can become exacerbated when a child's family lacks ongoing access to adequate health care. Children in poverty are also at a higher risk of abuse and neglect, teen pregnancy, substance abuse, depression, arrest and incarceration, and welfare. (Source: VI Kids Count Data Book 2007 -- CFVI) //2009//
***/2010/ According to the USVI Kids Count Data Book 2008, 29.5% of the child population, ages 0-18 years (total=28,786) lived in poverty in 2006. This represents 8,491 children, a 6.3% decrease from 2005 (35.8%) growing up in households with incomes below the federal poverty level. The national average has remained at 18% from 2004-2006. The reduction in numbers is accounted for by the decrease in the overall child population between 2005-2006; 13.8% fewer single mother families with children living in poverty (2828 from 3281 in 2005); and an increase in families earning income between $35,000 and $50,000. Child poverty is significantly tied to single motherhood due do lack of income stability. Child poverty in single mother families (7,125) remains consistently high at 46.7%. 70.6% of all families with children living in poverty were headed by single mothers. //2010//***

Income Comparison 1999 and 2002 of Families below poverty level: Families below poverty level

based on income earned in 1999 was 7,635. Children under age 18 years in families below the poverty level represented 5,862 in 1999. Families with no husband present was 4,521 (1999). Total individuals represented 24,637 in 1999.
/2007/ In the 2004 VICS, families below the poverty level were 8,933 (2004) or 21.5% of the population. Families with children under 18 years represented (4,119); with children under 5 years (1,510); and ages 5-17 years (3,637). The numbers revealed children under age 5 with the least and the highest were children under age 18 and ages 5-17 years experiencing poverty based on income earned. (Source: 2003-2004 VICS, EC Center, UVI, Poverty Status in 2002 Families; 2000 USVI Census Poverty Status in 1999 Families) //2007// (Please see Table 5: Income Comparison 1999 and 2002 of Families below poverty level under Appendices/State Support Documents.)
/2008/ 27,170 of 27,588 (98.5%) VI families with and without children reported earned income in 2004. One in five of these families earned less that $15,000 per year (20.3% or 5,512 families). This equates to approximately $10 a day per person for a family of four and is 22% below the federal poverty threshold. Nearly two out of every five families earned less than $25,000 per year (39.2% or 10,634 families). (Source: VI Kids Count Data Book 2006 -- CFVI) //2008//

Cost of Living Indicators: Studies have shown that the cost of living in the Territory is about 30% higher than Washington, D.C., the place with which the Territory is usually compared. The VI inflation rate is currently about 3.1 percent.
/2007/ There has been a reported increase of the consumer price index (CPI) of 4.1% in 2001, 6.3% in 2002, 8.7% in 2003 to 11.5% in 2004. This averages 2.6% a year increase. //2007//
/2009/ The consumer price index averaged a 5.5% increase for the period 2004-2006. //2009//
***/2010/ The cost of living in the VI is estimated to be 33% higher than most US jurisdictions. The VI has the third lowest wage offerings of US jurisdictions. This gap has steadily widened as real (inflation-adjusted) incomes in the VI have declined slightly over the past 15 years. (Source: VIBER. December 2008) //2010//***

The 2000 USVI Census Educational Attainment data shows that of the 65,603 persons 25 years and over 60.6% were high school graduates or higher and 16.7% received a bachelor degree or higher. Individuals with less than a ninth grade education represented 18.5%, and persons who received a ninth to twelve grade education but no diploma represented 20.9%. (Please see Table 6: 2000 USVI Census Educational Attainment under Appendices/ State Support Documents.)
/2009/ In 2005, nearly half (48.5%) of youth age 18-24 had not achieved high-school completion, up from 35.9% the previous year. Thus, the rate of high school completion in 2005 for VI youth age 18-24 was 51.5% (a steep drop from 64.1% the previous year). Only 4.3% of youth in this age group went on to earn a college degree by age 24. Virgin Islands females in this age group fared slightly better, with a high school graduation rate of 57.2%, though less (by 10 percentage points) than the previous year. Female college achievement dropped, with 4.8% of females age 18-24 completing college compared to 8.4% completing college in 2004. (Source: VI Kids Count Data Book 2006 -- CFVI) //2009//

Table 6: Comparison of 2000 - 2006 USVI Educational Attainment

| | 2000 | | 2005 | | 2006 | |
|---|---|---|---|---|---|---|
| Educational attainment | Number | % | Number | % | Number | % |
| 25 years and over | 65,603 | 100 | 71,048 | 100 | 76,909 | 100 |
| Less than 9th grade | 2,133 | 18.5 | 4,813 | 20.8 | 13,845 | 18 |
| 9th to 12th grade, no diploma | 13,743 | 20.9 | 20,721 | 29.1 | 14,382 | 8.7 |
| High school graduate, includes equivalency | 17,044 | 26.0 | 14,048 | 19.8 | 21,615 | 28 |
| Some college, no degree | 9,425 | 14.4 | 9,386 | 13.4 | 10,052 | 13.1 |
| Associate degree | 2,269 | 3.5 | 3,444 | 4.8 | | |

4,197 5.5

| | | | | | |
|---|---|---|---|---|---|
| Bachelor's degree | 6,841 | 10.4 | 5,547 | 7.8 | 8,772 11.4 |
| Graduate/professional degree | 4,148 | 6.3 | 3,089 | 4.3 | 4,046 5.3 |

***/2010/ Source: VICS 2006, Eastern Caribbean Center, University of the Virgin Islands.***

***Public and non-public school enrollment as of 2000 is 25,620, a decrease in 2,955 or 10% in the last 10 years. This represents 90% of the total number of children of school age. Data indicates that 17% of teenagers drop out of school usually in the first year of high school. The majority of drop outs are male (53%). It is estimated that approximately 12.6% of youth not in school are also unemployed. There is only one institution of higher learning in the Virgin Islands, the University of the Virgin Islands, which has a campus on St. Croix and St. Thomas. There is some indication that persons are beginning to access on-line education through the Internet; however, data is not available at this time on the amount or the impact. (Source: DHS Community Assessment 2003)***
***/2007/ Department of Education records show a public secondary school dropout rate of 5.0 % in the 2003-2004 school year, an increase of 10% over the previous school year. The ratio of male to female dropouts was about equal across both districts, 44% female in St. Croix and 45 female in St. Thomas. (Source: Department of Education, Office of Planning, Research and Evaluation 2004-2005). //2007//***
***/2008/ The VI high school dropout rate for the 2004-2005 school year is reported at 10.5%. In comparison the national high school dropout rate remained at 8.0%. Ninth grade continues to be a year of high risk for dropping out of the public school system, with the highest numbers, 6.7%. The ratio of male to female dropouts remained equal across both districts, 42.4% female in St. Croix and 41.3 % in St. Thomas. High school dropouts frequently lack the minimum skills and credentials for a technologically advanced workplace. These individuals have a more difficult time securing gainful employment or job advancement, and usually receive a salary that is inadequate to support a family. (Source: VI Kids Count Data Book 2006 -- CFVI / Department of Education, Office of Planning, Research and Evaluation SASI Database) //2008//***
***/2009/ In 2005-06, the VI public secondary school dropout rate was reported by the VI Department of Education as 5.6% (440 students), an increase of 1.2 percentage points over the previous year (and an increase of 82 student dropouts, up from 358 dropouts). Ninth grade continued to be a year of high risk for dropout in the VI public school system, with the highest numbers: 138 dropouts (or 7.7% of enrolled ninth grade students). In 2005-06, the ratio of male to female dropouts was six boys to every five girls. In St Thomas the proportion was 62.1% male to 37.9% female. In St. Croix the roles were reversed, with a proportion of 56.4% female to43.6% male (about five girls to every four boys).***
*****Note: percentages reported are based on constituent school populations, not the territorial population. Numbers and rates reported are for the VI public school students, and do not include students in private schools. Youth who do not finish high school frequently lack the minimum skills and credentials for today's changing job market. These young people will have a more difficult time securing employment, advancing in a job, and receiving wages able to support a family adequately. When unemployed, these youth are at greater risk of engaging in antisocial and crime-related activity. //2009// (Source: 2007 VI Kids Count Data Book. CFVI). //2009//***
***/2010/ VI Department of Education reported a total public school enrollment of 5,133 students in grades 9-12 for school year 2007-2008. 403 dropouts, or 7.8%, were reported. 199 or 3.8% of these were enrolled in 9th grade. This compares to 353 reported dropouts in 2006 -2007. This data is not inclusive of private / parochial high schools. Kid's Count 2008 data for 2006 reports a 13.8% dropout rate in teenagers 16-19 years in a population of 6,128. This includes those who are not enrolled in school, are not high school graduates or may be employed full or part-time, and are considered "detached youth". These individuals are more likely to be unemployed or earn lower wages over their lifetimes than their peers with a high school diploma. They are also more likely to rely on public***

***assistance, have no savings, suffer poor health, become a single parent and have children who also drop out of school. This impacts the community in many ways and a strong commitment to the implementation of strategies for meeting the needs of this vulnerable population is crucial. //2010//*** Source: VI Dept. of Education Office of Planning, Research and Evaluation 2007-2008; 2008 VI Kids Count Data Book.

| Race/Ethnicity | 2007-2008 | 2005-2006 | 2004-2005 | 2003-2004 |
|---|---|---|---|---|
| Asian | 0 | 15.4 | 16.7 | 0.0 |
| American Indian | 0.2 | 0.0 | 0.0 | 11.8 |
| Hispanic | 1.0 | 8.0 | 6.8 | 9.6 |
| Black | 6.8 | 4.6 | 3.2 | 4.4 |
| White | 1.0 | 14.3 | 0.0 | 7.1 |

Language: English is the only spoken language at home for 74.4% of the population 5 years and over. A language other than English (Spanish, French, Indo-European language and Asian/Pacific Island languages) is spoken by 25.3% of the population 5 years and over. (Please see Table 7: 2000 USVI Census Spoken Language under Appendices/State Support Documents.)

Marital Status of Women: The 2000 USVI Census and 2004 VICS shows that of 46,557 in 2004 compared to 42,649 in 2003 females 15 years and over (39% in 2004 and 40%-2003) have never married. Similarly, 39% in 2004 and 40.1% in 2003 of the men 15 years and over have never married. (Please see Table 8: 2000 USVI Census Marital Status of Women under Appendices/State Support Documents.)

Children Living with One or More Parents: /2007/ The proportion of children living with two married parents is 12,934, a significant increase by nearly 5% to the 38.9% in 2003 and 34.1% in 2002. While it is an improvement over 2002, it is noticeably less than the 43.6% reported in 1990 and represents half of the amount of children in the United States that lived with both parents at 69%. //2007//

/2007/ Children with one parent are in households headed by single mothers were at 41.8%, an increase of nearly 2% over 2002. This compares to an average national rate of 23.8%. As of 2003, 35% of VI children were living in families headed by single mothers. St. Croix had the highest proportion of children at 41% or 7,061. On St. Thomas, 4,138 children or 28.1%; and, St. John 450 children or 32% lived with a single mother. //2007//

Disability Status of the Non-Institutionalized Population (Special Needs): Disability of persons (five years and over) such as severe hearing, vision impairment; and substantial limitation in their ability to perform basic physical activities; difficulty learning, remembering or concentrating, difficulty in performing activities of daily living, persons sixteen years and over are considered to have a disability if they have difficulty going outside the home alone to shop or visit a doctor's office. (Please see Table 9: 2000 USVI Census Disability Status of the Non-Institutionalized Population under Appendices/State Support Documents.)

Local Area Unemployment: St. Croix's economy is primarily based on manufacturing. Major industries include Hovensa Oil Corporation, V.I. Rum Industries, watch factories and several pharmaceutical companies. St. Thomas' economy is largely based on tourism and the retail industry. There was some weakening in the performance of the USVI economy during 2002 reflecting the general downturn in the US economy after September 11, 2001. There was negative growth in the tourism and hospitality sector and in manufacturing. The major sectors (construction, wholesale and retail trade, finance insurance, real estate and transportation), showed some marginal improvement over 2001, but was too soft to effect overall economic growth.

Performance over the past year (2004) showed improvement in some sectors of the economy.

The US economic expansion, gains from federal tax cuts, and lower interest rates resulted in increased tourism and business and financial activity. The strong performance of these two sectors helped to support growth and bolstered government revenues. However, the gains from tourist and local consumer spending, business activity, and mortgage refinancing were not strong enough to offset the drag from declines in the construction, trade, transportation and utilities, professional and business, information and other services sectors. Although the economy is improving, job growth remained stagnant and nonexistent. The labor market remained in a slump and ended fiscal year 2003 with a net loss of 1,570 jobs. Employment fell in every sector, except the financial activities, leisure and hospitality, and education and health sectors. The construction sector, a primary driver of employment growth over the past two years, lost the majority of jobs due to the completion of major private sector capital projects. Personal income spurred by tax cuts and lower mortgage rates sustained the economy last year. Growth in personal income was estimated at 2 percent. Despite a 3.6 percent drop in nonagricultural wage and salary jobs, the economy improved on the strength of consumer spending.

Job growth remained elusive for the first half of fiscal year 2004, and only a modest improvement was expected for the remaining months of the fiscal year. However, the economy is expected to experience a more balanced expansion in fiscal year 2005, given the continued expansion of the U.S. economy, and planned and ongoing capital investment projects. Underlying the expectations for growth is the beliefs that federal monetary and fiscal stimulus will continue, and business investment will continue to exhibit strong growth. Proposed changes to tighten the residency requirement for economic development incentive benefits have potential to disrupt the financial services sector which is a strong performer adding over $100 million to the VI economy. Over the next year, the Virgin Islands economic performance will be largely tied to the economic health of the national economy as well as to local economic development initiatives. The outlook for 2005 projects increases in the leisure and tourism industry, financial services and construction sector supported by major hotel and casino construction, upgrade and expansion of roads, housing and seaports, development of commercial and residential properties and Hovensa's Desulphurization unit.
/2007/The Virgin Islands economy is in the midst of an economic expansion, which is expected to continue into 2006. In spite of higher oil prices and challenges to the Economic Development Commission (EDC) program posed by the American Jobs Creation Act (H.R. 4520), the economy expanded for the first nine months of fiscal year 2006. This growth is owed to a vibrant tourism sector with record level visitors, strong business investment and financial services activity. Nearly all of the major economic sectors have demonstrated marginal to modest growth over the past year. The outlook for the final quarter of fiscal year 2005 and for fiscal year 2006 is one of continued, but slower growth tempered by the pending EDC ruling, and a slow down in consumer spending resulting from rising interest rates. (Source: VIBER August 2005) //2007//
/2008/ The economy continued to deliver good results in most sectors in the final quarter of 2006. Output and employment levels have improved, the unemployment rate has fallen to the lowest levels of the past six years, inflation rates remain under control despite a significant increase in oil prices, and government General Fund balance in experiencing a surplus. Several factors contributing to the good standing of the economy included revenue enhancement measures which led to a reduction in government expenditure, diversity in the economic base, unprecedented corporate profits from soaring oil prices, business investments and real estate development which led to record tax revenues. //2008//
/2009/ The economy performed well in 2007 with real economic growth about 3.6 percent. The strongest performing sectors were manufacturing, construction, tourism and business services. Manufacture, construction, tourism and business activity will continue as the primary movers of economic activity in the year ahead. Growth is expected to moderate as the effects of a slowdown in the US economy feed through. Other factors, including a run-up in oil prices and rising interests rates have begun to impact the local economy and cloud the outlook for business investment and consumer spending. Tighter credit conditions, the housing downturn and higher oil prices are likely to affect economic growth as investors and consumers' spending decrease. A decline in consumer spending is anticipated as consumers grapple with rising costs for food and other consumer goods, utility, consumer loans and interest rates on credit cards. Source: VIBER

December 2007 //2009//
***/2010/ Economic growth weakened under the impact of the weak US economy. High energy prices weighed noticeably on consumers and businesses. With consumer spending is significantly down, a contraction in both construction activity and private capital investment spending, economic activity slowed in the third quarter. Source: VIBER July 2008//2010//***

The territory's unemployment rate for the first quarter of fiscal year 2004 decreased by 1.6% from fiscal year 2003. The rate for St. Croix decreased to 11.1% from 12.9% the previous year. Total non-agricultural employment averaged 3.6% less, decreasing to 41,833 jobs from 43,406 jobs in the corresponding period in fiscal year 2003.
/2007/ For the first nine months of fiscal year 2005, the labor force increased 1.0 percent to 49,793 compared to 49,280 for the same period last fiscal year. The territorial civilian employment rate shows a 1.7 percent increase over fiscal year 2004 for the same period. The civilian unemployment rate fell to 8.9 percent in fiscal year 2004 and averaged 7.4 percent for the first nine months of fiscal year 2005. The rate for St. Croix fell to 10.8 percent in fiscal 2004 from 12.9 percent in fiscal 2003 and is down to 8.6 percent for 2005. The rate for the St. Thomas/St. John district is steady at 6.5 percent for fiscal year 2005. //2007//
/2008/ For fiscal year 2006, territorial civilian unemployment rate averaged 6.4%. The rate for St. Croix was 7.7% with St. Thomas-St. John at 5.4%. This is expected to be lower in 2007 due to increased business activity and tourism-related development of public and private sector capital projects. //2008//
/2009/ The territory's unemployment rate remained relatively stable between 2006 and 2007, edging down modestly by two percentage points, from 6.1 to 5.9 percent. A growth in total employment, from 48,495 to 49,547 was reported. In the private sector, increases primarily in the leisure and hospitality industry, in trade, business and miscellaneous maintenance services offset declines in other industry divisions. Public sector also grew by 238 to 12,698 over this period, with 92 percent of this gain in the territorial government. However, the island's labor force also expanded from 52,137 to 52,670, thus diminishing the effect of employment growth on the jobless rate. Both the St. Thomas -- St. John and the St. Croix districts exhibited the same trends, posting slightly lower rates between 2006 and 2007, at 5.0 and 7.1 percent respectively. Source: Bureau of Labor Statistics, VI Dept. of Labor CY 2006-2007 //2009//
***/2010/ The Territory's nine month average unemployment rate held steady at 5.8 percent. St. Croix was steady at 7.0 percent, while the rate for St. Thomas and St. John declined to 4.9 percent. Source: Bureau of Labor Statistics, VI Dept. of Labor / VIBER July 2008 //2010//***

Government/public sector employment declined about 1% with 11,503 jobs from 12,545 the previous year. Federal employment showed no major changes with 912 jobs down slightly from 919 in fiscal year 2003. Local government jobs are expected to continue to decline in fiscal year 2005 as part of the government's cost cutting initiatives through attrition, retirement and elimination of vacant positions.
/2007/ The number of local and federal government jobs have deceased by 1.6 percent in the first nine months of fiscal year 2005 when compared to the same period last fiscal year. Local government jobs have averaged 11,300 during this fiscal year and federal government jobs have averaged 869. Efforts by the administration to reduce local government jobs through attrition, retirement and the elimination of vacant positions have been met with great success. //2007//
/2008/ In fiscal year 2006, the number of local government jobs increased marginally to 11,476, while the number of federal jobs declined to 835. //2008//
/2009/ Public sector jobs increased about 2.0 percent in fiscal year 2007. The increase occurred in both federal and local government jobs. Local government jobs averaged 11,690, up 1.9 percent over fiscal year 2006, while federal government jobs averaged 848 or a 1.7 percent increase from last fiscal year. Source: VIBER December 2007 //2009//
***/2010/ Public sector jobs grew 1.5 percent for the nine month period to 12,776, from 12,587 for the same period last fiscal year. Local government jobs averaged 11,829, up 2.3 percent over fiscal year 2007, while federal government jobs averaged 947 or a 1.2 percent increase from last fiscal year. Source: VIBER July 2008 //2010//***

Second to government, the service industry employs the most V.I. workers. An upturn in the tourism and hospitality industry, specifically in hotel accommodations, has improved this sector's performance. The sector is expected to grow during the next fiscal year as demand grows in travel and tourist related industries. This sector includes hotels, business, legal, educational, auto and miscellaneous repair services.
Total private sector employment accounted for 70% of the territory's jobs. Average employment in this sector fell by 1.9% for the first six months of fiscal year 2004 to 28,959 jobs from 29,526 during the same period in fiscal year 2003.
/2007/Average employment in this sector fell by 1.0 percent in fiscal year 2004. There is a turn around in private sector jobs in 2005 as evidenced by 1.0 percent growth in the first nine months of fiscal year 2005. Growth is expected to continue into fiscal year 2006. //2007//
/2008/ A turn around in private sector jobs showed 4.7 percent growth in fiscal year 2006. Jobs in this sector increased to 31,702 from 30,289 in fiscal year 2005. This sector continues to account for 70 percent of the territory's jobs. //2008//
/2008/Leisure and Hospitality -- this sector comprised of hotels and related services showed an increase of 4.3 percent this fiscal year, from 6,974 jobs in fiscal year 2005 to 7,721. This increase occurred primarily in restaurants and hotels. Additional growth is forecast for 2007. //2008//
/2009/ The private sector remains the largest employer in the Territory, employing 7 in every 10 persons. This sector has improved in the past year adding more than 600 jobs. There were 33,248 private sector jobs, up 2 percent from 32,620 in fiscal year 2006. Continued improvement in jobs in this sector rests on the buoyancy of the tourism industry, capital investment and the general strength of the economy. //2009//
/2009/ The leisure and hospitality accounts for 16 percent of total employment. This industry averaged 7,320 jobs in fiscal year 2007, and had a job growth rate of 2.3 percent. The job growth driver was the arts, entertainment and recreation super-sector. An expanding hotel and villas industry and new restaurants, such added to the gains in the leisure and hospitality sector. Source: VIBER December 2007 //2009//
***/2010/ Private sector jobs account for 73 percent of wage and salary jobs. There were 33,446 private sector jobs compared to 33,432 last year. The leisure and hospitality sector showed modest growth for fiscal year 2008, averaging 7,532 jobs, an increase of 2.4 percent. Source: VIBER July 2008 //2010//***

Trade--both retail and wholesale accounted for 28% of all employed. The number of jobs in trade showed no improvement during the first six months of fiscal year 2004. Employment levels are expected to be flat for the remainder of fiscal year 2004, but may improve in 2005 as the economy expands and spending grows.
/2007/ The number of jobs in trade-6,910 has not improved during the first nine months of fiscal year 2005 when compared to 6,918 for the same period in fiscal year 2004. Employment levels in trade are predicted to be flat for the rest of fiscal year 2005. However, trade and retail jobs in particular are expected to increase in fiscal year 2006 as the economy expands and spending grown. //2007//
/2008/ The number of jobs in the trade sector improved by 1.5 percent in 2006. Trade and retail jobs are expected to increase in fiscal year 2007 with increased business activity and tourism related development which are anticipated to be the main drivers of economic growth over the next year. //2008//
/2009/ There were 6,973 jobs in the trade sector in fiscal year 2007- about 1.0 percent over fiscal year 2006. Retail trade jobs averaged 6,194 and were up 1.3 percent, while wholesale trade jobs averaged 779, down by 2 percent from last fiscal year. Trade jobs and retail jobs in particular are expected to continue to increase in fiscal year 2008 with the opening of new retail stores. Source: VIBER December 2007 //2009//
***/2010/ The trade, transportation and public utilities sector averaged 8,743 jobs in 2008, up 1.3 percent over the last fiscal year. The trade sector contributed about 40 percent of sales annually and 19 percent of the jobs in the economy. Retail trade jobs, representing 90 percent of the trade sector's total employment, increased 1.7 percent averaging 6,993 jobs. Wholesale trade jobs averaged 776, down by 2.1 percent from last fiscal year. Source:***

***VIBER July 2008 //2010//***

The construction sector had an average of 1,737 jobs in fiscal year 2003 and 1,660 in the first half of fiscal year 2004 down from 3,182 in fiscal year 2002. As capital projects neared or reached completion jobs in this sector disappeared. Permit value a leading indicator of growth, increased 82.8% in the first quarter of fiscal year 2004. Lower interest rates helped to fuel the strong growth in private residential and non-residential values.
/2007/ Construction sector showed signs of job growth. For the first nine months of fiscal year 2005, this sector averaged 1,798 or 7.3 percent growth over the corresponding in Fiscal year 2004. Construction is expected to be strong over the next year supported by major hotel and casino construction, the upgrade and expansion of roads, housing and seaports and the development of commercial and residential properties//2007//
/2008/ This sector experienced strong growth in fiscal year 2006 averaging 14.8 percent over the previous year. The growth was mainly supported by continued major hotel construction, and other on-going development of capital projects including affordable housing developments and road construction territorially. //2008//
/2009/ Activity in the construction sector, as measured by the number and value of approved development and the value of building permits, has softened signaling the completion of major tourism-related development, housing and seaports, and the development of commercial and residential properties. The number of construction jobs averaged 3,144, in fiscal year 2007 nearly 200 jobs more than the previous fiscal year. Most of these jobs resulted from retrofitting and maintenance projects in the oil industry. There was an average 3,370 jobs in the industry in the first quarter of fiscal year 2008. //2009// Source: VIBER December 2007.
***/2010/ Jobs in the construction sector declined averaging 3,419 for the first nine months of fiscal year 2008 compared to 3,643 for the corresponding period in fiscal year 2007. Source: VIBER July 2008 //2010//***

Finance, Insurance, and Real Estate accounts for 4% of the territory's employment. This sector showed strong growth in fiscal year 2003 and employed 2,304 or 16% more jobs fiscal year 2002. Growth continued for the first half of fiscal year 2004 with an average of 2,395 jobs and is expected to improve in fiscal year 2005.
/2007/ The financial services sector was one of the most vibrant in the past year. For the first three quarters of fiscal year 2005 the number of jobs averaged 2,543 or 3.4 percent over the same period in fiscal year 2004. The strength of this sector in 2006 is dependent on the federal monetary policy and most importantly on the outcome of H.R. 4520. //2007//
/2008/ This sector grew by less than one percent in fiscal year 2006. The lack of growth points to uncertainties in the Economic Development Commission (EDC) program brought about by the American Job Creation Act 2004 that drastically changed residency requirements. Due to the stiffer residency requirements a number of EDC beneficiaries closed their operations, drastically reducing substantial tax revenues for the territory. //2008//
/2009/ The Financial services sector continues to show decline in jobs, albeit marginal. Jobs in this sector fell by 1.0 percent in fiscal year 2007 compared to 2006. The number of jobs averaged 2,576, down from 2,602 in fiscal year 2006. The decline of this sector points to uncertainties in the Economic Development Commission (EDC) program brought about by the American Job Creation Act 2004 that drastically changed the residency requirement. Because of the stiffer residency requirements a number of EDC beneficiaries closed their operations, thereby drastically reducing substantial tax revenues. //2009// Source: VIBER December 2007.
***/2010/ This sector held 6 percent of total employment, and continued to show a decline averaging 2,470 jobs down from 2,493 for fiscal year 2007. Expectations for business expansion in the next 12 months are negative given the flagging state of the economy. Source: VIBER July 2008 //2010//***

Manufacturing which accounts for 5% of nonagricultural jobs, which averaged 2,038 for the first half of fiscal year 2004, up slightly from 2,023 for the same period in fiscal year 2003.
/2007/ The number of manufacturing jobs has averaged 2,146 for the first nine months of fiscal year 2005, up slightly for 2,043 for the same period in fiscal year 2004. This represents a 5.1

percent growth primarily in the oil industry. The major commodities produced by this sector, in addition to watches, are refined petroleum products and rum. There should be continued improvement during the year with increased efforts by the VI Port Authority and the Economic Development Authority to attract new industries to the territory//2007//
/2008/ This sector experienced 9.0 percent growth over last fiscal year. Growth is expected to continue in 2007 and will primarily be concentrated in the oil and rum industries. There were strong gains in both the volume and value of its major export -- refined petroleum. Strong demand and higher oil prices have created record growth in oil profits which have benefited the territory. This has led to significant growth in corporate income taxes paid to the government. //2008//
***/2010/ The manufacturing sector contributes about 11 percent of GDP and accounts for 5 percent of jobs. There was an average of 2,314 manufacturing jobs in the first nine months of fiscal year 2008, similar to last year. Source: VIBER July 2008 //2010//***

Transportation, communications and public utilities remained stable for 2003 and account for 6% of all employment. Jobs in the sector were decreased by 1.2% for the first six months of fiscal year 2004 when compared to the same period in 2003 and employment is likely to remain stable for the remainder of 2004 and is expected to improve in 2005. (Source: VIBER - May 2004)
/2007/ Jobs in this sector are up nearly 1.0 percent for the first nine months of fiscal year 2005 when compared to the same period last fiscal year. Employment in this sector is unlikely to change for the remainder of 2005, but should improve in 2006. (Source: VIBER August 2005) //2007//
/2008/ Jobs in this sector increased 2.4 percent over last fiscal year. Employment in this sector is expected to improved in 2007, particularly in the area of retail trade. Source: VIBER December 2006 //2008//
/2009/ This sector holds the second largest share of jobs (19%) in the economy and averaged 8,635 jobs in 2007, a 1.0 percent increase over fiscal year 2006. //2009// Source: VIBER December 2007.
***/2010/ Jobs in transportation, warehouse and utility fell marginally by 0.3 percent to a nine-month average of 1,633 jobs. Source: VIBER July 2008 //2010//***

General labor force trends: According to the Bureau of Labor Statistics the labor force fell to 48,460 in fiscal year 2003 from 49,346 in fiscal year 2002. For the first half of fiscal year 2004, the labor force averaged 47,582. Civilian employment declined 1.2 percent for the first half of fiscal year 2004, down to 43,415 from 44,062 for the same period in fiscal year 2003. The territorial civilian unemployment rate which averaged 9.5% in fiscal year 2003, decreased to 8.8 percent in fiscal year 2004. /2007/ The total VI labor force for fiscal year 2004 averaged 47,508 from 48,460 in the same period in fiscal year 2003 according to the Bureau of Labor Statistics. For the first nine months of fiscal year 2005, the labor force increased 1.0 % to 49,793. Fiscal year 2005 civilian employment showed a 1.7% increase over the same period in fiscal year 2004. The territorial civilian unemployment rate averaged 7.4% for the first nine months of fiscal year 2005. //2007//
/2008/ According to the latest labor force estimates, the number of employed persons in the territory rose slightly over one thousand between 2005 and 2006. The largest increase was in the goods - producing sector (+ 740), primarily in the construction industry (+ 657). The services -- providing sector also exhibited gains, however more modestly (+322), with payroll growth in retail trade, educational and health services, leisure and hospitality services along with a minute increase in territorial government employment. Consequently, the labor force also expanded from 51,159 in 2005 to 51,831 in 2006, the number of jobless persons fell by 414 to 3,192 and the jobless rate dropped from 7.0 to 6.2 percent over the year. In the district of St. Croix the unemployment rate moved lower from 8.2 to 7.3 percent while the St. Thomas -- St. John district posted a drop from 6.2 to 5.2 percent during this period. The unemployment rate which averaged 6.4% in 2006 is expected to lower in 2007. This is due to anticipated growth in most sectors of the economy during this period. (Source: V.I. Dept. of Labor, Bureau of Labor Statistics). //2008//
***/2010/ There were 49,549 persons employed in civilian jobs, with 21,306 on St. Croix, and 28,243 on St. Thomas and St. John; a 0.3 percent over the 49,418 persons employed for***

***the corresponding period in fiscal year 2007. (Source: VIBER July 2008) //2010//***

Currently, tourism is the strongest performing sector of the VI economy and has experienced steady growth over the last fiscal year. Air and cruise ship arrivals have increased notably over the last two years, spawning a surge in hospitality related services such as hotel stays and restaurant services, transportation needs, recreation facilities and retail services to construction. This growth is expected to continue throughout the decade. (Source: Strategic Workforce Investment Plan 2005-2007: VI Dept. of Labor).

Mass Transit System: The Virgin Islands Transportation (VITRAN) mass transit system became operational in FY95. VITRAN provides transportation between remote locales, the main towns, and along the major thoroughfares. Buses are equipped and available to provide transportation for individuals with disabilities who require use of wheelchairs or other assistive devices. Major cutbacks in the scheduling and operation of these buses limit the service available to the public. Private taxi services are frequently utilized as the primary mode of transportation.
/2007/ The VITRAN system, under the auspices of the Department of Public Works, Office of Transportation, is responsible for coordinating and providing public transportation to residents of the Virgin Islands. This agency also seeks federal funds to finance public transportation initiatives and programs in support of the Territory's public transportation infrastructure. VITRAN-PLUS Para-transit Services (VITRAN-PLUS) provides public transportation to certified disabled persons, in accordance with the Americans with Disabilities Act. //2007//
***/2010/ Although the VITRAN mass transit system continues to provide transportation between the main town areas and along major thoroughfares, it does not provide extensive coverage in remote locales. VITRAN Buses are equipped to provide transportation for individuals with disabilities, but bus service is becoming limited to the public, thus impacting access to health services, leaving many individuals to use private taxi service, "Safaris" at a cost, and family and friends based upon their availability; which impedes the ability to keep appointments at health care provider sites, a main contributing factor to missed appointments. //2010//***

Environment: A unique factor, which affects the territory's infrastructure, is the increased incidence of powerful hurricanes, which have struck the territory in the past decade and a half. In 1989, the devastating Hugo struck St. Croix and destroyed 95% of the homes. In 1995, Hurricane Marilyn, a powerful category III hurricane, struck St. Thomas. On St. Thomas, 92% of the homes were damaged (habitable) or destroyed (inhabitable); on St. Croix and St. John, 71% and 86%, respectively of housing units were affected (Source: MMWR Vol.45/No.4). In 1997, Hurricane Georges, a category II hurricane, caused additional infrastructure damage. . During this period the Federal Emergency Management Agency (FEMA) offered millions of dollars to aide in the islands' recovery. In addition, the tourist industry suffered a loss of millions of dollars. In November 1999, Hurricane Lenny- category II- passed south of St. Croix and caused additional damage to buildings and the infrastructure. While there were no major storms in the past two years, the territory and its residents continue to experience the economic impact of high insurance rates.

In-migration: There is in-migration of undocumented residents from neighboring Caribbean islands. Based on geographic proximity to British possessions of Tortola, British Virgin Islands, and the island of Hispaniola-Santo Domingo and Haiti, immigrants come to deliver in the Virgin Islands in order to ensure U.S. citizenship for their offspring. They are uninsured and ineligible for any formal government programs. Most of the pregnant women present without records of prenatal care. In complicated pregnancies, critical newborns are cared for at the expense of the local hospitals and ultimately the Government of the Virgin Islands. Communication difficulties are also encountered. Actual numbers for undocumented residents are unavailable and estimates vary due to lack of data from reliable and knowledgeable sources. Additionally, this population is considered itinerant and constantly changing. They generally live in certain geographic areas, are non-English speaking, and access the health care system only when necessary. Language differences presented a challenge for effective communication.

/2007/Data is not collected regarding immigration status by the program. The increasing number of uninsured children identified with special health care needs in this population whose families are not qualified for Medical Assistance is having an impact on the program. While the absolute numbers may be small, the impact of being the primary source of payment for direct services including specialty care is not negligible. //2007//

Welfare Reform: In the Virgin Islands, the programs affected by changes in the Personal Responsibility and Work Act are: Public Assistance, Food Stamp Program, Child Care and Development Block Grant, and Job Opportunities and Basic Skill Program (JOBS). The specific changes occurring in these programs are:
1) Persons receiving cash awards under the Aid to Families With Dependent Children (now called Temporary Assistance to Needy Families-TANF) have lifetime benefits for a five year period only;
2) Immigrants must have paid in 40 quarters of social security, individually or combined with a spouse, before they can receive benefits, unless they are in a special exemption category outlined in the Law;
3) Any one between the ages of 18-50 years, who are able bodied without dependents and are not engaged in work or some work activity, can only receive Food Stamps for a period of three months in a three-year period;
4) Under the appropriations portion of Title IV Child Care, Section 418 (d), the U.S. Virgin Islands has been determined ineligible to receive an allotment from new Mandatory and Matching child care funds;
5) As a result of work requirement for recipients for TANF, referrals to the JOBS Program will increase significantly. Additional activities required will be short-term training programs and jobs.

Temporary Assistance to Needy Families State Plan became effective July 1, 1997. Changes affecting Food Stamp recipients who are able bodied became effective November, 1996. The immigrant policy became effective for Food Stamp recipients on April 1, 1997 for persons already receiving assistance. New applicants to the program were affected by the original date of enactment, August 22, 1996.

The Department of Human Services annual report for fiscal year 2004 shows a total of 2,260 persons who were recipients of assistance through various income maintenance programs -- 1,210 adults and 1,050 children. TANF recipients numbered 351 adults (93 or 26% from St. Thomas/St. John; 258 or 78% on St. Croix); and 1,025 children (285 of 28% from St. Thomas/St. John; and 740 or 72% from St. Croix). It is significant to note that in July of FY 2002, the five year life-time benefits expired for those recipients of TANF from its inception. This has had a major impact on St. Croix where employment opportunities are limited. A temporary assistance program was initiated using local funding to assist those clients on St. Croix who are in training or apprenticeship programs. In the last five years, there has been a 59% decrease in TANF recipients. From FY 2003, there has been a significant increase in adults receiving general assistance up by 65%. The Department of Human Services summarizes the impact of Welfare Reform as follows:
-A reduction in the number of persons receiving Food Stamps, resulting in the number of stamps issues and impacting the economy overall.
-The work requirement for families with children will increase the cost of childcare significantly and funding in this area is extremely limited.
/2007/ From FY 2004, there has been an increase by 17% of adults receiving TANF Benefits. From 1997 to 2005, there has been a decrease of over 71% of total TANF clients. In FY 2005, a total of 2,177 persons were recipients of assistance through the various programs: 1,270 adults and 907 children. //2007//
/2009/ DHS annual report for FY 2007 shows a total of 3,042 persons receiving assistance through various income maintenance programs. TANF recipients numbered 490 adults ( 157 or 32% in the St. Thomas-St. John District; 333 or 68% in the St.Croix district); 1,413 children (372 or 26% in the St. Thomas-St. John District and 1,041 or 74% in the St. Croix District. In FY 2007 the total number of households with children under 19 years of age receiving TANF benefits was 315. //2009//

The Agricultural Research, Extension and Education Reform Act of 1998 (AREERA), Public Law 105-185, changes some of alien eligibility provisions and broadens alien eligibility to make more aliens eligible for Food Stamp benefits.

The Farm Security and Rural Investment Act of 2003 (Public Law 107-171), commonly referred to as the 2003 Farm Bill, restores food stamp eligibility to many legal immigrants who lost eligibility under the 1996 Welfare Reform legislation. The effective date for qualified legal immigrants who have been in the country for five years to regain eligibility was April 1, 2003. A small number of disabled immigrants have their eligibility restored prior to that date.

The Food Stamp Program is one of the territory's major prevention programs for low-income families. Additionally, when a disaster is declared, the Food Stamp program, upon approval of the US Department of Agriculture Food and Nutrition Services regional office administers the Disaster Food Stamp Program. This program provides one-time food stamp support to families who have suffered loss due to disaster. In addition, the program, while not considered a revenue generating program brings into the territory $19 million per year. This not only helps in the prevention of poor nutrition but supports local grocery stores by increasing revenue and jobs which in turn increase money circulation within the community. In FY 2004 4,532 households received allotments monthly, 1,566 on St. Thomas/St. John or 35%; and 2,966 on St. Croix or 65%.
/2007/ During fiscal year 2005, a total of 4,673 households received monthly allotments with 2,949 (63%) on St. Croix and 1,724 (37%) on St. Thomas/St. John. A total of 13,547 received food benefits monthly 8,742 (65%) on St. Croix and 4,805 (35%) on St. Thomas/St. John. (Source: Department of Human Services Annual Report 2005) //2007//
/2008/ During fiscal year 2006, a total of 4,777 households received monthly allotments with 2,989 (62.5%) on St. Croix and 1,788 (37.4%) on St. Thomas/St. John. A total of 13,608 individuals received food benefits monthly 8,759 (64.3%) on St. Croix and 4,849 (35.6%) on St. Thomas/St. John. There were 11,241 children under 19 years of age (82.6%) in these households. Source: Department of Human Services Annual Report 2006. //2008//

The Welfare Reform Act of 1996 mandated all states and territories to implement Electronic Benefit Transfer (EBT) systems before October 1, 2003. The EBT system provides electronic access to food stamp benefits through clients' use of a magnetic stripe card.

The Temporary Assistance to Needy Families (TANF) continues to operate under the Welfare Reform regulations. The Department continues to partner with the Departments of Labor, Health, Education, Housing and the University of the Virgin Islands in meeting the needs of TANF recipients. (Source: Department of Human Services Annual Report)

Movements towards Managed Care: Health Maintenance Organizations (HMOs) do not exist in the Virgin Islands. Medicaid managed care is also non-existent in the territory. The Government of the Virgin Islands, as the largest employer, offers health insurance coverage to its employees. Health insurance fees and increased costs of government health insurance continue to be a barrier for low-income families. In June 2001, the Government of the Virgin Islands renegotiated the contact for health insurance, which resulted in increased premiums to the employees. The insurance coverage reimburses at a 80/20 ratio for care received in the territory, and 60/40 for services received outside of the territory. Government employees are required to participate in the government group insurance plan

## B. Agency Capacity

III - B. STATE AGENCY CAPACITY
Statutory Authority: The Department of Health (DOH) functions as both the state regulatory agency and the territorial public health agency for the U.S. Virgin Islands. As set forth by the Virgin Islands Code, Titles 3 and 19, the Department of Health (DOH) has direct responsibility for

conducting programs of preventive medicine, including special programs in Maternal and Child Health, Family Planning, Environmental Sanitation, Mental Health, and Drug and Substance Abuse Prevention. DOH also is responsible for health promotion and protection, regulation of health care providers and facilities, and policy development and planning, as well as maintaining the vital statistics for the population.

DOH provides Emergency Medical Services, issues birth and death certificates, performs environmental health services, and conducts health research and surveys. The Department is also responsible for regulating and licensing health care providers and facilities, and assumes primary responsibility for the health of the community in the event of a disaster.
The department employs providers and administrators from every aspect of health care, and manages several programs, both federal and local; to meet the needs of the community. Services are focused towards accomplishing the Department's aim and are administered by 34 activity centers under the following four (4) divisions:
Office of the Commissioner
Division of Fiscal Affairs
Division of Administrative Services and Management
Preventative Health Services
The department includes three health care facilities, two district offices and field offices, as well as the central office, located on St. Thomas.

The Virgin Islands Department of Health is designated as the agency in the Virgin Islands for administering the Maternal and Child Health and Children With Special Health Care Needs Program (MCH & CSHCN) pursuant to Title 19, Chapter 7, Section 151 of the Virgin Islands Code.

The Virgin Islands Department of Health's Maternal and Child Health & Children With Special Health Care Needs (MCH & CSHCN) Program activities are directed at improving and maintaining the health status of women, infants, children, including children with special health care needs and adolescents. The MCH & CSHCN Program is the cornerstone for family and comprehensive health service systems.

Vision statement: The US Virgin Islands Department of Health envisions an effective health care system that will increase the territory's wellness by educating and mobilizing the communities toward the development of positive lifestyles.

Mission: The Virgin Islands Department of Health is the territorial authority committed to:
•Provide quality health care
•Regulate, monitor and enforce health standards to protect the public's health
•Educating, mobilizing, and empowering the community toward the development of positive lifestyles; and
•Protecting the health and safety of the community.

Values:
• Dedication to the public good
• Caring customer service
• Excellence in job performance
• Efficient teamwork
• Respect for self, clients, and co-workers
• Integrity and confidentiality

Goals: The five major performance goals guiding the department encompasses all legal mandates as spelled out in the V.I. Code. These goals also address the focus areas for achieving the department's mission.
• Improve health outcomes and access to quality health care
• Provide health education, health promotion and community-based programs

• Enhance mental health and substance abuse services
• Achieve excellence in management practices
• Enforce laws and implement rules and regulations

The mission of the MCH & CSHCN Program is to promote and improve the health of women, children, adolescents and families, including those with special health care needs; and assure access to quality health care services for high-risk and special needs groups through planning and coordination of comprehensive health services systems.

Goals & Objectives: MCH & CSHCN goals are: (a) to assure access to comprehensive coordinated, family-centered, culturally-competent primary and preventive health care services for all women and children, especially low income and vulnerable populations, in order to promote and improve pregnancy and birth outcomes; (b) to improve the health of children and adolescents including those with special health care needs through comprehensive, coordinated, family-centered, culturally-competent primary and preventive care; and (c) to provide a system that eliminates barriers and health disparities and strengthens the MCH infrastructure.
The goal of the Prenatal/Perinatal Program is to prevent maternal and infant deaths and other adverse perinatal outcomes by promoting preconceptual health, assuring early entry into prenatal care, and improving perinatal care.

Program Capacity: The Title V MCH & CSHCN Program is administered as one integrated program within the Department of Health. This allows for better and more efficient coordination of services in MCH. The program provides health care services for mothers, infants, children, youth, adolescents and their families. The program also provides and coordinates a system of preventive and primary health care services for this population. These services include prenatal and high-risk prenatal care clinics, postpartum care, well child care, high risk infant and pediatric clinics, care coordination and access to pediatric sub-specialty care for children and adolescents with special health care needs.

***/2010/ As a mostly rural-suburban commuting community, the U.S. Virgin Islands is designated as a Health Professional Shortage Areas (HPSAs). With a score of 43.70, on a scale 0 to 100 for low need for primary care services, the U.S. Virgin Island clearly has a need for primary care services. Likewise, the Medically Underserved area designation is based on the proportion of low-income families on all three islands; the score for St Croix is 16 while St. Thomas and St. John scored 15 out of a possible score of 25 indicating a high need. Both of these designations are important because they illustrate increasing challenges for Virgin Islands families to obtain quality health care toward minimizing or eliminating disparities resulting from the economic barriers so common place. //2010//***

For children, ages 0-21, with disabilities and chronic conditions, the program provides preventive and primary care, therapeutic and rehabilitative services. The MCH & CSHCN program offers a system of family-centered, coordinated, community-based, culturally competent care, assuring access to child health services including medical care, case management and home visiting, screening, referrals and assistance obtaining a medical home. Services are provided either directly through Title V or by referral to other agencies and programs that have the capability to provide medical, social, and support services to this population. Public Health Nurses provide parental counseling and education regarding growth and developmental milestones, proper nutritional practices, immunizations; service/care coordination and home visiting services to high risk children and their families.
Clients with acute illnesses or require medical procedures beyond the capability of the medical staff to provide are referred to the Emergency Department for assessment and treatment. Residents of the territory are not eligible for the Supplemental Security Income (SSI) Program which provides assistive devices, therapeutic or rehabilitative services beyond acute care to children under the age of 16 with disabilities. The Medical Assistance Program (MAP) does not provide these services, due to the Medicaid Cap imposed by Congress. These services are provided on a limited case by case basis by the Title V Program when required. Nursery referrals

are received on all high-risk newborns who are followed in the MCH & CSHCN clinics. Infants without any high-risk factors are referred to well child clinics. Infants classified as high-risk or at-risk for a disability due to biological, physiological, or environmental factors or diagnosed with medical conditions are followed in the Infant High Risk clinics. High-risk referral patients are screened to receive a home visit, and family assessment. Screening is conducted by Infants and Toddlers' (Part C of IDEA) service coordinator in order to identify newborns as part of the Infants and Toddlers (Part C) Child-Find system. Public health nurses assess the developmental needs of infants and toddlers who are at-risk due to psychosocial or biological risk factors.

The Charles Harwood Complex is the principal site for MCH service delivery on St. Croix. All clinic staff and services returned to the Charles Harwood Complex during September and October 2004 at the completion of renovations which started in 2002. This complex has been modernized to a state of the art, one stop health facility. This complex houses approximately three hundred employees representing several programs and divisions.

Clinics include: Prenatal Intake for new patients in which the history, physical, risk assessment, PAP smear, and laboratory referrals are done; Midwife Clinic or Revisit Clinic for routine follow-up and counseling; Teen Prenatal and Family Planning Clinics; and Perinatal/High Risk Clinic for the management of obstetrically or medically complex cases. Patients with emergencies are referred to the Obstetrical Ward for evaluation and treatment. In-patient deliveries are performed by the hospital's Obstetricians and Midwives.

/2007/ Renovation of Charles Harwood Memorial Complex has been successfully completed. The complex has been modernized to a state of the art one-stop health facility that serves, on average, two hundred patients daily.//2007//

Diagnostic services, such as ultrasounds and laboratory services, are available at the hospitals or at private facilities. The government does not operate a public health laboratory on either island outside of the hospital facilities.
On St. Croix, prenatal care capacity consists of one Nurse Midwife (vacant), one Obstetrician (.1FTE), and a Territorial Perinatologist (.1FTE) at the MCH Clinic. The Obstetrician/Gynecologist performs the initial medical evaluation, manages medically complicated patients, and provides limited gynecological services. The program is actively recruiting a Certified Nurse-Midwife and OB-GYN Nurse Practitioner for St. Croix through the Bureau of Health Professions/National Health Service Corps, as this island is designated as an underserved area by HRSA. However, salaries and compensation are not comparable to the U.S. mainland creating challenges to filling these positions. On St. Thomas, prenatal services are administered by the Community Health Clinics with one Midwife, one Nurse Practitioner, an Obstetrician, (vacant) and Perinatologist (.1FTE). The Perinatologist also serves as the Director of Women's Health and conducts clinics at East End Health Center, Frederiksted Health Center, and at the Morris F. deCastro Clinic on St. John. The St. Thomas/St. John district did not meet the minimum score to be designated as an underserved area. However, the Bureau of Health Professions does allow for individuals eligible for Loan Repayment to be recruited and employed.
/2007/ The midwife position St. Thomas has been filled.//2007//
/2009/ The OB-GYN position on St. Thomas has been filled. Women's Health services are also provided on St. John at the DOH Morris DeCastro Clinic. //2009//

Patients are referred to the WIC or Community Health Nutritionists for dietary assessments, counseling, and follow-up. Dental services are provided at Charles Harwood, on St. Croix, and the Roy Lester Schneider Hospital, on St. Thomas, and are operated under the auspices of the Division of Dental Health Services. Social workers assist patients with assessments and applying for Medicaid and other services.

Health services are offered through a system, which employs a variety of health care professionals to include Pediatricians, Nurses, Pediatric Nurse Specialist, Clinical Care Coordinators, Social Workers, Dentists, and Dental Hygienists. Allied health professionals may

serve territorially when necessary. As of March 2004, there are 177 physicians licensed to practice in the territory. This includes eighteen (18) Obstetricians, fifteen (15) Pediatricians and twenty-nine (29) General/Family Practitioners. (Source: V.I. Board of Medical Licensure, 2004).

The three main facilities for primary care services are MCH & CSHCN Clinics, PHS 330-Community Health Centers, and hospital-based Community Health Clinics. On St. Thomas MCH's principal facility is located in the western district, the Community Health Clinics at the Roy Lester Schneider Hospital serve the mid-island district, and the East End Health Center is located in the east district. On St. Croix, the Frederiksted Health Center is located on the western end of the island, and the MCH & CSHCN principal facility is located in the east at Charles Harwood Complex. On Cruz Bay, St. John, the Morris DeCastro Clinic is the site for the MCH & CSHCN monthly Infant/Pediatric high-risk clinic.

Through a series of outreach activities, the MCH & CSHCN Unit identifies children who have health problems requiring intervention, suffering from disabling, or chronic medical conditions, or at risk. A system of public health nursing, based on specified health districts, is an integral component of providing family-centered, community health services. Sources of child-find include referrals from the Queen Louise Home for Children, Early Childhood Education, Head Start, and private providers. Pediatricians, Nurses, Social Workers, a Physical Therapist Assistant, an Occupational Therapist, Audiologist, and Speech Pathologist are the major providers of direct services. The Infants and Toddlers Program employs Service Coordinators on each island.

Hospital newborns with biological, established, or environmental risks are referred to the Infant or Pediatric High Risk clinics based on established criteria. At one year of age, infants are re-assessed and transition to the Well Child Clinic or the Pediatric High Risk Clinic. The Infant and Pediatric High Risk Clinics offer comprehensive, coordinated, family-centered services. Screening is done for developmental delay using the Denver Developmental Screening Tool. Social Workers complete an assessment of the family and home environment, existing support structures, and financial status. A diagnostic assessment and therapeutic plan is developed by the clinical staff. Through an appointment system, children with special health care needs are referred to the sub-specialty clinics by the primary care physician. The Physical Therapist serves territorially. The Speech Pathologist on St. Thomas may travel to St. Croix to provide services and conduct screening.

Population-Based Services: The MCH & CSHCN Program offers three population-based preventive services: immunization services; the newborn genetic / metabolic screening program; and the newborn hearing screening program. Each is discussed under related Performance Measures. Funding awarded from the Centers for Disease Control and Prevention for a four-year Cooperative Agreement starting September 1, 2001, enabled continuation of newborn hearing screening under the auspices of the MCH & CSHCN Newborn Screening and Follow-up Program. The Infants & Toddlers Program continues as the primary referral source for children identified with hearing loss/impairment requiring amplification or habilitative services. This CDC funding ends on August 31, 2005. These services will continue under the auspices of the Title V Block Grant. Significant improvement in newborn hearing screening rates before hospital discharge since the inception of the program was noted. See discussion under Performance Measure #12.
/2007/ CDC funding for this project ended on August 31, 2005. Services are continued under the auspices of the Title V Block Grant. See discussion under Performance Measure #12. //2007//
/2008/ The program provided funding for Division of Dental Health to obtain and apply dental sealants in the school age population, with a focus on 6-9 years old.//2008//
/2009/ The MCH Program collaborates with the VI Immunization Program, which provides vaccines (Vaccine for Children-VFC), assessment of immunization levels, monitoring of vaccine usage and evaluation of vaccine reaction. //2009//
***/2010/ Newborn hearing screening continued this fiscal year. Discussion under NPM #12 and SPM #5. Metabolic / genetic screening for inheritable disorders is expanded to 48 conditions using mass spectrometry. Perkin Elmer Genetics Laboratory currently***

***provides screening. Discussions are underway for transition of newborn screening to both hospitals by the end of FY 2009. Discussion under NPM #1. Collaboration continues with the VI Immunization Program. The goal of the Immunization Program is to ensure that 95 percent or more of all children living in the Virgin Islands up to age 6 are fully immunized in accordance with the Advisory Committee on Immunization Practices (ACIP) recommendations. The program administers thousands of vaccines a year to children and adults. There are three immunization clinics that administer shots and provide counseling activities on the various types of vaccines administered. The Vaccines for Children (VFC) Program provides vaccines at no cost to children from birth to 18 years who are American Indian or Alaskan natives; under-insured or have no insurance, and are covered by Medicaid. Discussion under NPM #7. //2010//***

Direct Care: The program assures access to preventive and primary health services for infants, young children and adolescents, including allied health and other health related services. Specialty clinics provide pediatric specialty services that are generally unavailable or inaccessible to low-income, uninsured or underinsured families. Cardiology clinics provide assessment and evaluation of heart disease and provide medical treatment and management. Hematology clinics provide evaluations and family education for children with sickle cell disease, hemoglobinopathies, and follow-up for other hematological disorders such as leukemia. Orthopedic clinics provide specialized exams, diagnostic procedures, and intervention recommendations for conditions such as scoliosis, and other orthopedic conditions. Other specialty clinics such as Pulmonology and Neurology are also available. Diagnosis, treatment and follow-up care for the full range of neurological disorders in children, including comprehensive evaluation and assessment for multiple neurological and/or complex neurological conditions are provided. Comprehensive services for children with known genetic syndromes, including comorbid neurodevelopmental/neurocognitive diagnosis, treatment, and ongoing care are also available. Specialty services are offered to all children in the territory regardless of ability or inability to pay.
/2008/ Pediatric pulmonology services are no longer available. These services are provided by a pediatric allergist/immunologist on-island.//2008//
***/2010/ There is a perpetual shortage of pediatric specialties in the Virgin Islands. The specialists that we have on island serve primarily the adult population. It is not cost effective to send children to Puerto Rico to have general screening for orthopedic concerns, evaluations of cardiac murmurs or neurologic issues, therefore these sub-specialty pediatricians provide regular valuable services in the territory. The majority of children referred to the Orthopedist are for evaluation of genu varum, genu valgum and scoliosis. Several of those children have mild cases that should resolve spontaneously; however, there are several that have required special shoes or other devices and need follow up within a few months. It would not be cost efficient to send those children back and forth to Puerto Rico for these types of evaluations. Finances must be reserved for those individuals who require surgical intervention for problems like progressive scoliosis, Blount's Disease, slipped femoral epiphysis, aseptic hip necrosis or even clubbed feet. The post surgical follow up of these patients is done at MCH clinic and not in Puerto Rico.***
***The ability to have a Pediatric Neurologist available for early screening and evaluation for suspected developmental delay has been beneficial in getting many children into early intervention programs, thus providing good outcomes as compared to the past, where these children diagnosed with a developmental delay in Head Start, hence requiring more intensive therapy. With the Neurologist coming to MCH, financial resources are available to help families perform the genetic and metabolic testing required to make a diagnosis for some of the developmental delays noted in these children. With the increased number of premature infants surviving with histories of intraventricular hemorrhages and other usual complications of extreme prematurity, more children are being referred to the Neurologist for evaluation -- all of whom cannot be sent to Puerto Rico. Just as the national numbers for Austism have increased, so have the numbers increased locally requiring neurologic evaluation. The Neurologist collaborates with the pediatricians and the allied health***

***services to create a plan of action for these children. With the formation of the Autistic Spectrum group (Virgin Islands Autism Network-VIAN), a plan of action should be formalized over the next year. //2010//***

Enabling Services: Translation services at clinics are available through bilingual staff for Hispanic-Spanish speaking clients and French-dialects from the eastern Caribbean islands. Transportation services are not routinely offered but can be arranged with the administrative office. Off-island air transportation may be provided based on need and availability of funds. Home visitation is conducted on a priority basis for high-risk populations. Nutrition services are offered by Women, Infant and Children's Program (WIC), and the Community Nutrition Program.
There was a noticeable, though not documented, increase in the number of uninsured children of undocumented families who have not met the residency or other legal requirements to apply for medical assistance, or who would not otherwise receive health care, seeking health care and sub-specialty health care through the program. Provision and delivery of these services enabled high risk populations to establish relationships with the health care system.
/2008/ Recruitment efforts are underway to employ 2 bilingual interpreters (French Creole and Spanish) per island on a part-time basis. There are an increasing number of non-English speaking families seeking services which places demands and creates challenges on full-time clinical staff who speak more than one language. Recruitment for vacant staff positions will give preference to qualified bilingual providers. //2008//

***/2010/ Partnerships are being established with private providers offering nutritional services to children and adolescents. Through these collaborative efforts, the MCH program seeks to access and impact a greater segment of the maternal and child population including children with special health care needs. The Women with Focus program is a non-profit organization geared towards improving the nutritional health of the community. They advocate healthy diets and encourage healthy and active lifestyles. //2010//***

Infrastructure-building Services: The program continued activities directed at assuring the availability of the infrastructure necessary to delivery of services to the maternal/child population and to increase access to quality health care for families who lack sufficient financial resources to meet the costs of medical care. Access to staff development activities, training and technical assistance to assure continuous quality of care was provided. Improvement in data collection activities for monitoring and evaluation of services to this population was undertaken during this fiscal year. Challenges remain with a lack of adequate data linkages and child health information systems to support program activities including data collection and analysis. Program policy and procedures manual is revised to address the need for standards and guidelines for service provision, data collection, training and quality assurance/improvement.
/2008/ The program will continue activities directed at assuring the availability of the infrastructure necessary to deliver services to the maternal/child population and to increase access to quality health care for families who lack sufficient financial resources to meet the costs of medical care. Review and update of program policies and procedures to ensure standards of care are being met. Activities related to on-going needs assessment and implementation of identified strategies, policy development, quality assurance and evaluation services, development and implementation of health care standards and protocols, and professional development activities for both MCH/CSHCN staff, providers and community partners will continue.//2008//
/2009/ Planning activities directed at addressing infrastructure and development of a comprehensive continuous quality improvement plan to assist in building organizational development and system capacity were initiated in FY 2007. It is anticipated that these activities will continue throughout FY 2008 and 2009 with development and implementation of a strategic plan to improve coordination and integration of MCH services, assist MCH leadership and management in the development and implementation of a comprehensive CQI plan to ensure ongoing assessment,program planning, evaluation processes and practice, and improve ability to develop and conduct 5-year needs assessment. Technical Assistance from MCHB has been awarded for the initial phase of these activities. In the area of workforce development, a two

year program - Leadership Education and Developmental Disabilities (LEADD, was started in September 2007. The program is presented by the Westchester Institute for Human Development and the School of Public Health, New York Medical College in partnership with the VI University Center for Excellence in Developmental Disabilities (VICEDD) at the University of the Virgin Islands (UVI);and funded by a grant from MCHB. LEADD broadens the opportunities for continuing education and leadership development available to MCH, health and other professionals in the VI, especially as related to children with developmental disabilities and their families. The program uses blended learning distance education methods which combines live classes, computerized virtual classroom instruction, online discussion and self-study. Indviduals registered in this four-semester, two-year program receive academic credits offered by the School of Public Health, New York Medical College. Courses are taught by faculty from the Westchester Institute of Child Development and include major topics of current interest including introduction to the public health perspective, understanding and addressing health disparities and cultural competence, family-centered care, distinctive concerns of the Caribbean and Virgin Islands, leadership and genetics and other specific topics. //2009//

***/2010/ The Continuous Quality Improvement (CQI) Leadership Team received Technical Assistance (2) in organizational capacity assessment and initiated the process for the development of the five-year needs assessment for the MCH Block Grant. The objectives for the sessions included, but are not limited to: an increased understanding of CQI and its relationship to an effective MCH system of care; increased understanding of the needs assessment process; determining current organizational capacity to develop and sustain the MCH system of care, and the ability to define the MCH system of care and the pyramid of services.***
***Three MCH & CSHCN Program staff (2-RN's, 1-MD) are enrolled in the LEADD Graduate Certificate in Children with Special Health Needs Program along with enrollees from DOH Division of Mental Health and Juan F. Luis Hospital. The Graduate Certificate Program prepares future public health professionals to address the needs of children with neurodevelopmental disabilities and their families with emphasis on the disparities in access and outcomes experienced by families from diverse backgrounds. This interdisciplinary certificate program is open to clinical and public health professionals and students from a wide range of disciplines. While the certificate may be undertaken as a focused learning experience, the course of study also serves as an entry to master's degree programs for those who decide to pursue graduate studies. //2010//***

## C. Organizational Structure

III - C. ORGANIZATIONAL STRUCTURE

The MCH & CSHCN Program is a unit within the Department of Health, one of 14 government departments. The Department of Health is headed by the Commissioner of Health. The Department of Health was reorganized in July 1999. The executive staff consists of the Commissioner of Health, Administrator for Policy and Program Planning, Deputy Commissioners for Divisions of Public Health Services, Fiscal Affairs, Legal Council, Administrative Services and Management and Health Promotion and Disease Prevention.
The Department of Health's mission is to provide quality health care, regulate, monitor and enforce health standards to protect the public's health. This is achieved by open communication with the public, informing them of health care options, thus serving as a catalyst to assist them in making educated choices on receiving the highest quality of health care. The agency is committed to building a sound policy and program infrastructure that reflects the twenty-first century. The Department is the sole state agency responsible for coordinating and providing a focal point for territory wide public health efforts on behalf of Virgin Islanders and visitors to the territory.
/2007/ As mandated by Virgin Islands Code, Titles 3 and 19, the Department of Health (DOH) has

direct responsibility for conducting programs of preventive medicine. The agency is committed to building a sound policy and program infrastructure through employing providers and administrators from every aspect of health care. //2007//

The MCH & CSHCN Program reports directly to the Deputy Commissioner for Public Health Services. The Program is operated as a single organizational unit and serves as both local and state agency. This single State agency is authorized to administer Title V funds and is responsible for both Maternal and Child Health and Special Needs Children Services. The Administrative Unit is composed of the Director and Assistant Director of MCH & CSHCN, Program Administrator St. Croix, Fiscal Officer, St. Croix and Office Manager, St. Thomas.

***/2010/ The Assistant Director position was filled in November 2008. This individual will have primary responsibility for the coordination of all activities related to the five-year needs assessment including convening an advisory committee / work-group through re-engagement of partners and stakeholders to assist with the process, gathering of existing and new data and identifying priorities for preparation of the final plan. //2010//***

The MCH & CSHCN Program is guided by an advisory council, a thirty (30)-member body charged with the responsibility of advising the Administrative Unit of the MCH & CSHCN Program. The Advisory Council assists in developing goals and objectives, long range program planning, identifying service gaps, locating resources, and monitoring the quality of services provided. Members of the Council include representatives from: Family Planning, Departments of Education, Human Services and Justice, Infants and Toddlers, 330-funded health centers, parents and guardians of children with special health care needs, child care providers, hospitals and faith and community-based organizations. The MCH Director, Assistant Director, Program Administrators and SSDI Administrator are ex-officio members. The Advisory Council was revitalized in 2003 with the election of a dynamic chairperson who played a major leadership role in revision of the By-Laws of the Council. Several committees were formed to address issues and challenges within the program including program evaluation, quality improvement, public awareness and family participation. Members of the council also served on the Ad Hoc committee for the five-year needs assessment. The Council was instrumental in review of the Block Grant narrative and provided valuable input.

***/2010/ Due to limited resources, the Council was unable to have a joint meeting this past fiscal year. However, individual members have reviewed and provided input on the draft 2010 needs assessment instrument and approved the Adolescent Health questionnaire in its current form. Members have also volunteered to form a core group for review of the Block Grant application and as facilitators for proposed focus groups for both surveys. //2010//***

Hospitals: There are two public hospitals, Juan F. Luis Hospital on St. Croix, and Roy Lester Schneider Hospital on St. Thomas. The hospitals are under the management of a Territorial Board and two District Boards established under Bill No. 20-0366, "The Virgin Islands Government Hospitals and Health Facilities Corporation Act," in 1994. The Commissioner of Health serves as a non-voting, ex-officio Board of Directors member.

In 1999, Bill No. 20-0030 granted partial autonomy to the hospitals. The Chief Executive Officer has the power to appoint the Medical Director, Chief Financial Officer, managerial personnel, health providers, and other professional and non-professional personnel. The bill further granted fiscal autonomy by establishing a Hospital and Health Facilities Fund for the purpose of receiving, managing, and disposing of monies or property on behalf of the V.I. Government Hospitals and Health Facilities Corporation. The Commissioner of Health remains with the legal authority to issue a certificate of need and license hospital facilities.

Both hospitals were built at 250-bed capacity. A Level II nursery exists on St. Thomas, headed by a Neonatologist. In 1999, a Neonatologist joined the staff of the Juan F. Luis Hospital. /2002/

Infants on St. Croix are no longer transferred to St. Thomas for Intensive Neonatal Care. Newborn patients requiring neurosurgery or cardiac surgery may be transferred to Puerto Rico or Florida.
In June 2001, the Juan F. Luis Hospital received accreditation from the Joint Commission on Accreditation of Hospital Organizations (JCAHO) for a three year period. Full re-accreditation was received in 2004 for an additional three year period.
The Roy Lester Schneider Hospital on St. Thomas received accreditation from the Joint Commission on Accreditation of Hospital Organizations (JCAHO) for a three year period in December 2003.

***/2010/ The Roy Lester Schneider Hospital on St. Thomas is a 169-bed acute care Joint Commission (JCAHO) accredited facility. Meeting the health care needs of its community has required constant expansion of medical services, and recruitment of highly qualified and board certified medical professionals. The hospital is a popular provider of choice for the USVI community, and given the services now offered, it is the convenient option for many patients from throughout the Eastern Caribbean region who are referred here for treatment.***
***Likewise, St. Croix's Juan F. Luis Hospital is a 165-bed facility which is also fully accredited by the Joint Commission on Accreditation of Health Care Organizations. //2010//***

330-Funded Community Health Centers: The Frederiksted Health Center, (FHC), serves approximately 25,000 on the western side of St. Croix. Adjacent to FHC is the Ingeborg Nesbitt Urgent Care Center (INC), which provides walk-in services to patients of all ages. Critical patients are transferred to the Juan F. Luis Hospital and Medical Center. Laboratory services and pharmaceutical services are provided on site. FHC services include: Family Practice, Family Planning, Prenatal, Pediatrics, Women's Health, Social Services, and Immunizations. The St. Thomas East End Medical Center (STEEMCC), on St. Thomas, serves the medically under-served population on the heavily populated eastern end of the island. Services include general primary medical care, diagnostic, laboratory, and referral for diagnostic x-ray procedures, family planning, HIV testing, and immunizations. OB-GYN care includes gynecological care, prenatal care, antepartum fetal assessment, referral for ultrasounds, genetic counseling and testing, and postpartum care. Dental care services include preventive, restorative, and emergency.

An affiliate agreement has been signed by the Governor of the Virgin Islands, placing the governance of the health centers under the authority of the governing boards. The health centers were incorporated as not-for-profit entities. Policies regarding fiscal and personnel issues are being finalized. By June 2005, it is anticipated that both 330 centers will be private corporations independent of the Department of Health. An Office of Primary Care has been established to coordinate Primary Care services within the Office of the Governor. A Territorial Primary Care Plan is being developed.

Myrah Keating Smith Health Center: Located on St. John, this center serves as an ambulatory facility. In 1999, management of this facility was turned over to the Roy L. Schneider Hospital and the Hospital's Board.

Community Health Clinics: The St. Thomas Community Health Clinic is located at the Roy Lester Schneider Hospital. This clinic provides prenatal, gynecology, family planning services, and pediatric services. On St. Croix, the Community Health Clinic is located at the Charles Harwood Complex. Services include eye clinics, diabetic clinic and primary care for adults. This activity center screens, diagnoses and treats patients with medical problems such as diabetes, hypertension, cardiovascular disease and arthritis. Sub-specialty clinics which provide services in neurology, urology, podiatry, orthopedics, minor surgery, wound management and allergic/dermatological diseases are conducted. An Epidemiology Committee meets quarterly to discuss issues or concerns related to bio-terrorism activities and emerging/infectious disease that may impact the territory including SARS and Anthrax, and collect data of epidemiological impact.

Emergency Medical Services: The Emergency Medical Services (EMS) is the agency charged with the provision of pre-hospital emergency medical care. Inter-island patient transfer services between St. Croix and St. Thomas and Puerto Rico or the continental United States are privately arranged. This agency is responsible for management of the ambulance system, and participates in the delivery of emergency care within the hospital emergency department and the Health Department clinics. Training is provided for all levels of EMT's including Pediatric Advanced Life Support (PALS), and Advanced Cardiac Life Support (ACLS), Emergency Vehicles Operators Course (EVOC), and basic cardiac life support courses for the public.
The MCH & CSHCN program was awarded an EMS-C grant for a three year period, March 2003-February 2006, in partnership with the Division of Emergency Medical Services (EMS) to improve and increase preparedness activities to address pediatric emergencies including natural disasters, bio-terrorism and mass casualty occurrences that incorporate components for pediatric needs. The purpose of this funding is to develop and implement a sustainable Emergency Medical Services-Children (EMS-C) system to strengthen the existing capability to provide pediatric emergency services. The goal is to ultimately reduce morbidity and mortality from severe illness or trauma by improving the quality of pediatric emergency medical care and supporting injury prevention. By the end of the project period in February 2006, the EMSC program is anticipated to be fully integrated into the Division of EMS.
/2008/ The Emergency Medical Service-Children Partnership Grant was integrated into the Division of Emergency Medical Services from the MCH & CSHCN Program. The three year funding will continue the development and implementation of a sustainable EMSC system to expand the VIEMS system to improve the quality of health care and overall emergency response system for children, youth and adolescents. //2008//

An enhanced 9-1-1 telephone system has been implemented, allowing the dialing of a single series of numbers to request Police, Fire, or Emergency Medical Services. These calls are received at a single location, and then transferred to the respective agency. Pursuant to Act No. 6333 passed by the Legislature and approved by the Governor on December 2, 1999, effective April 1, 2000 a $1.00 emergency service surcharge is added to all residential and commercial telephone bills. These collections are placed in a special fund, the "Emergency Services Special Fund," to be used by the Commissioner of Health, the Commissioner of Police, and the Director of Fire Services for the purchase of equipment or supplies necessary to provide, maintain, and improve emergency medical services, fire services and 911 emergency equipment.

Bio-terrorism: The Department of Health (DOH) is the lead agency responsible for coordinating the Public Health response in the case of a biological attack. The mission of the Bio-terrorism Program is to prepare the public health and hospital infrastructure to handle threats to the community's health. Through systems of biological, chemical, and laboratory surveillance, coupled with communication and alert systems the U. S. Virgin Islands will be able to track and respond to potential threats on the populations' health. The vision of the program is to create a state of the art system in which public health and hospitals have the ability to respond to identified threats before they become a public health threat. Funding is received from the Centers for Disease Control and Prevention for Public Health Preparedness & Response to Bio-terrorism, and Health Resource Services Administration for Hospital Bio terrorism Program.
/2007/ This Program is now the Office of Public Health Emergency Preparedness and Response. In order to fulfill the Public Health Emergency Preparedness and Response Program's responsibility of protecting the public from an act of bio-terrorism it is necessary to have an active communicable disease surveillance system where information is received, processed and analyzed at a central location. The Department of Health hired an Epidemiologist (who is based in St. Croix) funded through the Bio-terrorism program to handle that task. Long-term plans for the bio-terrorism program include the establishment of a basic public health laboratory to address some of our community's basic needs such as water, food, and milk testing. Several training activities were conducted for local health care workforce and outside emergency responders in the public and private sector on disaster preparedness and public health response to disaster. Training activities are on-going. //2007//

## D. Other MCH Capacity

III - D. OTHER CAPACITY

Role of the Parents: Parents have played a vital role in the program planning and evaluation, quantitatively, and qualitatively. Parents are involved in preliminary planning and implementation of each program. Parent representatives were part of the core committee, which developed the client survey instrument for the five year needs assessment, and were hired to conduct interviews. There are parent representatives on the MCH Advisory Council and the V.I. Interagency Coordinating Council. Parents participate in off-island training, which involves improving the quality of services being provided to infants and children with and without special health care needs.

***/2010/ Partnerships are being formed with Parent Involvement Coordinators from the Department of Human Services and the Department of Education. Through these efforts we seek to gain participation from a cross sector of the population that we serve. //2010//***

***/2010/ Here to Understand & Give Support (HUGS-VI ) is a Parent Support Group for parents and caregivers of individuals with Special Needs. HUGS mission is to bring families and partners together to empower those with disabilities through learning, sharing, recreation and social events. HUGS-VI was created by parents who have children with Special Needs to support each other, to offer training programs teaching about Special Education Rights for persons with Special Needs, to fund and maintain Vocational Training enterprises, protected workshops, and social programs, plan for future respite care and adult day programs and living homes fundraising through grants and donations, offering respite care, performing arts programs, scouts, summer camps, sports and the arts for persons with special needs and to serve children and adults with developmental disabilities. //2010//***

Health Planning: The Office of Health Planning is charged with the responsibility of reviewing all grant applications submitted by the MCH & CSHCN Program to ensure consistency with departmental objectives. This position remained vacant throughout fiscal year 2004.
/2007/ An Administrator was hired in May 2005. The Bureau of Health Planning is charged with the regulatory responsibility of administering the Certificate of Need (CON) program established by Title XIX of the Virgin Islands Code. The fundamental premise of the CON program is to restrain the ever-increasing health care costs; prevent the unnecessary duplication of health care facilities; and finally to achieve equal access to quality health care at a reasonable cost. //2007//

Vital Records and Statistics: Vital Records and Statistics collects, analyzes and disseminates vital events data in the territory. The program works with the courts, healthcare facilities, the University of the Virgin Islands and other agencies involved in births, deaths, marriages and divorces. Its mission is the registration of births, deaths, and other vital statistics in the territory. This office generates the health statistics, leading causes of death and maintains a cancer registry for the Virgin Islands. Due to technical and managerial personnel shortages, this office remains limited in its capacity to analyze data. A Director was appointed for this office in 2003. Full computerization of the Vital Registry system is still not realized after several years of efforts. The electronic vital registry system has not been implemented.
/2007/ One of the major goals of Vital Records and Statistics is to procure a software in order to maintain an electronic vital records registry. This will allow the program to interact with the National Center for Health Statistics and other states in a more timely manner. Software demos have been viewed and funding has been identified. An RFP was sent out during the 4th quarter of FY-05. The application will allow for electronic generation of birth and death records. It will also allow for web access and input of data from the hospitals and funeral directors. Another goal is to publish health related data on the web. This will give the community faster access to information pertaining to the wellness of the territory. //2007//

Office of Grants Writing and Program Analysis: The Office of Grants Writing and Program Analysis was established in 1999 to incorporate monitoring, and program evaluation. The office is charged with the responsibility for locating appropriate grants, provides assistance in preparation of and reviews grants applications, and monitors any conditions or terms applied to the grant. The office also ensures that the intergovernmental review process is conducted when applicable. The position for a Coordinator is currently vacant, although efforts at recruitment continues.
/2007/ This position was filled during fiscal year 2005 with a Federal Grants Coordinator.//2007//

Health Information Technology (HIT): Formerly Office of Management Information Systems and Communication Services, is responsible for evaluating and recommending hardware and software for the various programs/divisions. Responsibilities include: installation, maintenance, training and ongoing support of all computer and communication systems. Additional functions include research and development of new applications for technological advancements, which can reduce costs while improving efficiency. The goal of HIT is to automate all programs/divisions within a comprehensive network for electronic data sharing and telephone interconnects via a technologically advanced communication network. Internet access, E-Mail, data sharing, and an Integrated Health Information System for all clinics. The network is anticipated to be linked into the government-wide computer environment for e-mail, processing personnel requests through the Department of Personnel, and access to the Financial Management System.
/2008/ In FY 2006 the priority goal for HIT was working towards achieving standards for public health data systems as set by the JOINT COUNCIL OF GOVERNMENTAL PUBLIC HEALTH AGENCIES. The Center for Disease Control and Prevention (CDC), the Association of State and Territorial Health Officials (ASTHO), the National Association of City and County Health Officials (NACCHO), and the Health Resources and Services Administration (HRSA) joined forces and developed an "Integrated Health Information Systems Investment Analysis Guide. These groups are promoting the need for utilizing software that meets the needs of the various public health programs and integrates the data together for patients' referrals, treatment, data sharing, and vital statistics reporting and research.
The network will be linked into the government-wide computer environment for processing personnel requests through the Department of Personnel and access to the Financial Management System. Implementation of this activity is anticipated to be completed by January 2008.
Activities are on-going with programs within DOH to create a department wide network of information sharing. The public health clinical application HealthPro is being used to tie together all of our services and patient information for program reporting needs it eventually will be linked to hospital and Human Services.//2008//

Family Planning Program: Family Planning is authorized by Section X of the Social Security Act. The V.I. Family Planning Program was initiated in 1979 to support the provision of voluntary services primarily to low income persons. The mission of the Family Planning Program is: "To promote optimal health in our community, in the full understanding of the culture, habits and needs of our community, by assisting and counseling individuals, mainly women of childbearing age, and families to achieve the goals they have set for family size; by promoting healthy sexual attitudes and behavior, and by improving adolescents understanding and attitudes about human sexuality and contraception". The program provides: medical evaluations, human sexuality and contraceptive counseling, infertility management, genetic counseling, and social, nutrition, and health education referrals. The Family Planning Program's accomplishments were related to its mission to provide affordable, culturally sensitive educational, counseling and comprehensive medical and social services necessary to enable individuals, mainly women of childbearing age, to freely determine the number and spacing of their children, help reduce maternal and infant mortality and promote the health of mothers and children. The program generated 8,187 visits (13.5% or 973 more than FY 2003) where comprehensive, culturally sensitive family planning educational and medical services were provided. A total of 1,360 adolescents were reached through direct clinic services (a slight 4.7% decrease over FY 2003's 1,425 visits). There was a significant 49.3% decrease in outreach visits (718) for FY 2004. Outreach sessions were made

possible through the efforts of our clinical nurse educators and our adolescent peer educational group (which generated 185 contacts). The Frederiksted Health Care= family planning satellite clinic generated 88 or 13.2% more visits than FY 2003 bringing this year=s total to 751. The rate (59.0) for appointments continues to improve over the FY 03 rate (58.3). This implies better adherence to appointments. St. John has the best compliance rate (86.5) . This year, teens comprised 16.6 of all visits as opposed to FY 03 (19.8% ). The slight decrease implies a need to expand outreach to teens. It may also include teens who have Agraduated@ to adult status within the program. Screening of GC/Chlamydia in collaboration with the VI STD/HIV/TB Prevention Program was continued. The relocation to the renovated clinic/administrative areas at the Charles Harwood Complex on St. Croix on 3/29/04 allowed expansion of services and represented a positive improvement in infrastructure. /2007/ The 2005 Family Planning Annual Report (FPAR) data revealed an overall 6.9% increase in unduplicated users and 62.7% in encounters in 2005. A comparison of teen users from October 2004 to April 2005 yielded 757 versus October 2005 to April 2006 of 659. On-site counseling sessions were 658 and community-based sessions 60 with over 2085 participants. The venues were youth centers, elementary, middle and high schools (public and private), the University, public health forums, and private and public businesses.//2007//
/2008/ The 330-Health Centers reported 400 client visits. These clients are served at the Charles Harwood Site on St. Croix and Elaine Co. Bldg. Site on St. Thomas. The Teen Project Coordinator position for St. Thomas remains vacant mainly due to the low salary. Despite this challenge, clinical nurse educators, peer health educators and the St. Croix Teen Project Coordinator have conducted 75 outreach sessions (4.4 times more than FY 2005) and reached 2,381 teens (almost 3 times more than in FY 2005). //2008//
/2009/ Additional funding was received to incorporate HIV testing into three sites at Family Planning. Chlamydia screening was increased due to increased funding. Cervical cancer screening efforts continued with a slight increase of 1.3% in abnormal pap smears over FY 2006 noted. Clients identified are referred as per protocol guidelines. HIV Orasure testing also increased. However, no positives were identified. HIV screening is now extended to clients at the Elaineco site with the receipt of additional funding. Family participation is encouraged in the decisions of minors to seek family planning services. At the close of fiscal year 2007, the Teen Project Coordinator position for St. Thomas still remains vacant. Despite this challenge, clinical nurse educators, peer health educators and mostly the St. Croix Teen Project Coordinator have conducted 120 outreach sessions (45 more than FY 2006) and reached 2,348 teens ( about the same [2,381] as FY 2006. During these sessions information is provided to encourage and support delay in sexual activity; on sexual coercion; on abstinence; on refusal skills; and on protection against STDs and HIV/AIDS. //2009//
***/2010/ VIFPP seeks to ensure efficient and high quality reproductive health care services including family planning as well as the related preventive and medical treatment that will improve the overall health of individuals. It facilitates access to health information to encourage healthy responsible behavior among at risk youth's age 10-21 years. VIFPP is a forerunner in the encouragement and empowerment of families through proactive involvement in healthy behavior and disease prevention. The program directly impacts more than 5,000 individuals while indirectly impacting 25,000 children, youth, parents, and community residents in the VI. /2010//***

***V.I. Perinatal Inc.: VIPI was recognized as a community-based tax-exempt 501(c) (3) organization in 2003. VIPI applied for and received a Healthy Communities Access Program grant from HRSA in September 2004 to launch the "Promoting Healthy Families Initiative" (PHFI) to increase access of uninsured low income families into the public insurance program; increase the target population access to a family-centered, comprehensive, coordinated system of care; and to reduce the rate of pre-term births, diabetes, and hypertension in the target population. Over 500 individuals and their families have been recruited and served by outreach services, case management, transportation, health education, pharmacy assistance; translation services and prevention educational sessions focusing on nutrition, diet and food preparation. With a grant from the VI Government, VIPI also launched the "Healthy Families….Healthy***

***Babies Initiative" (HFHBI) which is the VI' s version of a Healthy Start model on St. Thomas. Outreach, case management, transportation and health education are the core services. The grant also allows VIPI to facilitate the re-establishment of the Fetal and Infant Mortality Review Committee as well as focus on fathers' involvement in prenatal care by offering training for social service providers and infant care giver skills for "dads". HFHBI outreach and case management staff has enrolled 25 high risk pregnant women and their families. VIPI continues to focus on increasing consumer presence to achieve broader consumer representation; identifying and enrolling clients most in need of perinatal services and implementing strategies to reduce infant mortality and morbidity on St. Croix. The program received local funding to expand services to the St. Thomas -- St. John district in Fiscal Year 2005-2006. See discussion under NPM # 15 & 18. The MCH & CSHCN Director is the Title V representative on VIPI's Executive Board.***
***/2009/ HFHBI expanded to the St. Thomas-St. John District in FY 2007. Local funding was obtained from the VI Legislature. A total of 93 clients were enrolled in the program and received case management services. Services provided at the VIDOH Community Health Clinic site and the St. Thomas East End Medical Center also include Spanish medical interpretation. A social marketing campaign was instituted with a target population of high-risk pregnant women with a focus on promoting early prenatal care. VIPI requested and received funds from the Bennie and Martha Benjamin for the purchase and donation of fetal monitors for VIDOH prenatal clinics. A Management Information System (MIS) has been developed to manage the data for PMMRC. An audit for births during 2000-2007 is in progress. Criteria are low birth weight less than 2500 gms and very low birth weight less than 1500 gms. The objective is to determine the common clinical indicators leading to preterm births in the territory. //2009//***
***/2010/ VIPI continues to provide services to low-income, uninsured, and under-insured high risk pregnant women. 141 women and their families were served since the program's inception on St. Thomas. 142 were served on St. Croix in FY 2008. A social marketing campaign on the "Importance of Early prenatal care " was implemented via radio ads. Case management services are at 2 provider sites -- Community Health -- St. Thomas, and Frederiksted Health Center -- St. Croix. The Perinatal Morbidity and Mortality Review Committee (PMMRC) activities included revision and completion of the Data Collection Survey Instrument, and contracted with a chart auditor who is currently conducting audits at Juan F. Luis Hospital on St. Croix. Interconceptional care was integrated into the existing module of care utilizing earmark funds received from the Office of the VI Cngressional Delegate. A workgroup was established to evaluate local capacity, create a local border health frame-work and conduct efforts for policy development. Efforts to collect data & quantify trends of non-citizens usage of local public health resources were made. It was proposed that available Border Health resources be identified to assist in addressing the financial and systemic burden placed on the territorial resources. Discussions were focused on the territory's ability to continuously and effectively respond to the health care needs of non-citizens. //2010//***

## E. State Agency Coordination

III - E. STATE AGENCY COORDINATION

The MCH & CSHCN Unit plays a leadership role in developing a comprehensive system of services. Agency and community resources include Departments of Health and Human Services, Developmental and Disabilities Council, Department of Justice (Office for Paternity & Child Support), Department of Education, Special Education/Early Childhood Program, Head Start Program, and Disabilities and Rehabilitation Services. The V.I. Advocacy Agency, Inc. and Legal Services provide an effective voice for persons with disabilities. Representatives of these agencies serve on the MCH & CSHCN Advisory Council, V.I. Interagency Coordinating Council, and the V.I. Alliance for Primary Care. They participate in planning and evaluating services for children with special health care needs.

/2009/ Several government agencies, programs, foundations or community based organizations provide services to women in their reproductive age, children and adolescents especially those with special health care needs. Coordination among all agencies is needed to reduce duplication of effort, fragmentation of services, and increase efficiency in the use of limited resources. VIDOH has established formal and informal relationships with other public agencies, academic institutions, and health care facilities which enhance the availability of comprehensive services for the MCH population. //2009//

Infant & Toddlers Program: The Early Intervention Program for Infants and Toddlers with Disabilities was established under Public Law (PL) 99-457. VIDOH is the lead agency and administers this grant via the Infants & Toddlers Program (ITP) supplementing the MCH & CSHCN Program, when public or private resources are otherwise unavailable, by providing early intervention services such as: service coordination, physical therapy, speech and language therapy, occupational therapy, vision therapy, special instruction, and family training. The ITP is a territory-wide, comprehensive, coordinated, multidisciplinary, inter-agency system of early intervention services for infants and toddlers (age birth through three), with disabilities and or developmental delays, and their families. The goal is to enhance the capacity of families to meet the special needs of their children. The program is supported by its Interagency Coordinating Council (ICC) whose membership includes parents of children with disabilities and or developmental delays, public and private sector service providers, and various other stakeholders. The ITP's collaborative efforts with the MCH & CSHCN Program are especially effective as shown above via its Child Find activities. /2007/The ITP strives to maintain a statewide system of early intervention services, enhance the Department's capacity to provide quality services, expand and improve existing early intervention services and encourage the Territory to enhance opportunities for children less than five years of age who would be at risk of having substantial developmental delays without access to early intervention services. See further discussion under NPM's 2,3,4,5. //2007//
***/2010/ As of December 2008, there were 143 infants and children eligible and enrolled in the IFP with Individual Family Service Plans (IFSP). Services include service coordination, family training, occupational and physical therapy, psychological services, special instruction, speech & language pathology, transportation, and vision services. The program contributes its success to its continued efforts to maintain early referrals to the program. Private physicians, hospitals, other public clinics, and child care centers are visited and Part C program information shared and disseminated. The program issues a written notice upon receipt of the referral to the primary referral source and provides feedback that indicates if the child is eligible. Early intervention services are rendered in the Part C of IDEA eligible child's natural environment and are provided during the early weekday evenings and on Saturdays, in addition to the work week times. Collaborative efforts with Early Head Start program to develop posters and contact information sheets also help to maintain early referrals; thereby helping the VI meet its target and improve services to infants and toddlers and their families. The Program also implemented television advertisements, and other collaborations are being initiated to increase early identification and referrals, and maintain rapport with primary referral sources, such as hospitals, clinics and private physicians. Representatives from the Program periodically visit private pediatricians to explain benefits, thanking them for referrals and provide E.I. program literature and posters . The program continues current efforts to maintain a comprehensive child find system, monitor referral sources and promote current outreach efforts. //2010//***

V.I. Interagency Coordinating Council: The V.I. Interagency Coordinating Council (VIICC) is charged with the task of advising and assisting the DOH in the implementing the Individuals with Disabilities Education Act. The VIICC includes representatives of state public agencies, such as the Department of Health, MCH & CSHCN, Department of Human Services, Department of Education, Special Education/Early Childhood Education, University of the Virgin Islands, public and private providers, advocacy agencies, parents of children with disabilities, and the VI Legislature. An Interagency MOU with the Departments of Health, Human Services, and

Education coordinates the early intervention services for children under three years. This agreement is to be revisited to include children 0 -- 5 years.
/2007/ The council continues to meet quarterly and works to help promote early intervention, improve the early intervention system and support the program in meeting its mandates. //2007//

Head Start Screening: A revision of the existing formal agreement between the Department of Human Services and Department of Health is currently in progress. The revised document reflects the role of the MCH & CSHCN Program in providing Speech Language and Audiometric/Hearing screening and referrals for follow-up specialty care.

Mental Health Services: Pursuant to Title III, Section 418, of the VI Code the Department of Health is designated as the single State agency for mental health, alcoholism and drug dependency. The division is organized into six (6) areas: prevention, assessment, intake, and evaluation; outreach, case management, and rehabilitation; crisis intervention; outpatient mental health; substance abuse and residential services. Major focus on the development of a community-based system of care began with the Child and Adolescent Service System Program (CASSP) Demonstration Grant. Achievements include the development of the VI definition of Severely Emotionally Disturbed (SED) children and adolescents. Mental health services to children include evaluation, assessment, and therapy. Services are provided by a psychologist and therapist, with consultation from the Department's Psychiatrist. The Division of Mental Health (DMH) Outpatient clinic on St. Croix reported a significant increase in referrals from schools, clinics, parents and private physicians for children with conduct and learning disorders which include ADD, ADHD and autism. There is a noticeable shift with more children and adolescents referred for services than adults. More than 50% of children followed are on medications for these disorders and require frequent and close monitoring. Services are provided in the least restricted environment and are available and accessible to all who need them. Service planning and delivery is client based and includes the participation of children and their families, with treatment based on family preservation when possible. Children and adolescents with SED needing multi-agency services will receive them in a coordinated fashion. /2007/DMH received Community Mental Health Block Grants awarded by SAMSHA to provide community-based mental health services to seriously emotionally disturbed children, adolescents, and adults. All of the children served have a diagnosis that has impaired their ability to function in school or the community. The State Incentive Program (VIP SIG) is targeted to provide substance abuse prevention services for youth between the ages of 12 and 17. //2007//
/2008/ In FY 2006, this activity center provided services to 246 children ages 0 -- 20. This included individual, family and group therapy; monitoring of medication and psychiatric evaluations. DMH - VIP SIG and the WIC Program signed a MOU toward improving delivery of service to qualified clients; ensuring awareness and access of WIC services to female substance abusers in the territory. VIP SIG program administered a 17-item Community Resource Assessment Survey across the Territory to identify organizations providing prevention services, the type of services provided, the proportion of budgets allocated to prevention, and the characteristics of the populations served. VIP SIG also developed a Needs Assessment-Youth Survey (VIYRBS), which was conducted Territory-wide in all public high schools and some private high schools in May 2006. //2008//
/2009/ VIP SIG primary focus is prevention of substance abuse and to promote healthy living for the VI population. The VI YRBS was conducted this year with full support and leadership by the then Deputy Commissioner for Education, an adjunct Council member; it was extremely successful. In 2006, approximately 3000 students completed the youth survey, and there are greater estimates of student participation for 2007. VIP SIG Project is conducting an extensive resource assessment to assess provider capacity and readiness for the implementation of evidence-based prevention programming across the Territory. These activities will drive strategic decision-making processes to identify specific domains and strategies to achieve positive immediate, intermediate and long term outcomes. All activities are currently in process or under development.//2009//
***/2010/ The division was reorganized into 3 areas: outpatient mental health services which includes intake, evaluation, and case management services; outpatient substance abuse***

***services, inclusive of outreach, intake, evaluation and case management services; and mental health residential services. //2010//***

Developmental Disabilities: The Developmental Disabilities Program is authorized under Public Law 94-103, the Developmental Disabilities Assistance and Bill of Rights Act of 1973. In the Virgin Islands, the Department of Human Services administers the Developmental Disabilities Program through its developmental services component. The developmental services component provides grants to public and private non-profit organizations. Services provided through these grants include legal advocacy, employment, training, and special transportation. The Developmental Disabilities Council advises the Department of Human Services in the performance of these functions.

VI University Center for Excellence in Developmental Disabilities (VIUCEDD), formerly VI University Affiliated Program, was established in October 1994 and is funded by the US Department of Health and Human Services, Administration on Developmental Disabilities and the US Department of Education, Office of National Institute on Disability and Rehabilitation Research. The VIUCEDD mission is to enhance the quality of life for individuals with disabilities and their families and to provide them with tools necessary for independence, productivity and full inclusion into community life. This is accomplished by providing a continuum of educational opportunities through which the student in Inclusive Early Childhood Education may earn a Certificate, an Associate of Arts Degree, and a Bachelor of Arts Degree. VIUCEDD also offers American Sign Language courses during the Fall and Spring semesters, and technical assistance to community groups serving individuals with disabilities .

Vocational Rehabilitation Program: The Vocational Rehabilitation Program is authorized by the Rehabilitation Act of 1973, Public Law 93-112 and its amendments. The program is administered by the Department of Human Services. The program offers services to eligible individuals with disabilities in preparation for competitive employment including: supportive employment through Work-Able, a non-profit placement agency; independent living services; provision of a vending stand program for visually impaired individuals; and in-service training programs for staff development. Under the Disabilities & Rehabilitation Services grant, Vocational Rehabilitation Services conducts assessments for determining eligibility, provide counseling, guidance, and referral, physical and mental restoration services, coordinates vocational, college activities, on-the-job training and transportation for individuals with disabilities. The grant provides funds for coordination of support services which include: interpreter services for individuals who are deaf, reader services for individuals who are blind, services to assist students with disabilities transition from school to work, personal assistance services, rehabilitative technical services and devices, employment and job placement services. The average age of individuals receiving services in 2004 was 20 years with 56% female and 44% male. Data on race and ethnicity is not available. (Source: DHS Annual Report FY 2004)

Women, Infants and Children Program: The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is authorized by PL 95-927, as amended. The VI WIC Program is 100% federally funded and is administered by the Department of Health. WIC serves as an adjunct to preventative health care services during critical times of growth and development, in order to promote and maintain the health and well being of nutritionally at-risk women, infants and young children. Persons eligible for the program include pregnant, breastfeeding and postpartum women, infants and children up to age five who are determined by a health professional to be at nutritional risk and meet income criteria. WIC promotes breastfeeding as the optimal infant feeding choice unless contraindicated. The VI WIC Program remains dedicated to provide family-centered nutrition education and services to WIC participants/caretakers in order that optimal growth and development of infants and children occur, and to assist in prenatal, postpartum and breastfeeding women making informed health and dietary choices for themselves and their families. An 86% breast-feeding rate among WIC post-partum participants was maintained. See discussion under NPM #11. /2007/ Nutrition Services (WIC) are provided to improve the nutritional status of its target population. These services are provided at no cost to participants

as defined in federal regulations. The VI WIC Program provided nutrition education, supplemental foods, food demonstrations on ways to use WIC foods, and referrals to other health and social services agencies. Nutritionists also provided high-risk nutrition education to WIC participants. See discussion under NPM #11, 14. //2007//

***/2010/ See discussion under NPM #11, 14. //2010//***

Community Foundation of the Virgin Islands (CFVI): CFVI was created to serve both donors and nonprofit organizations of the Virgin Islands that want to ensure the highest quality of life for both present and future generations. Its primary goal is to build a collection of permanent funds, which will be used to enhance the educational, physical, social, cultural and environmental well-being of the children, youth, and families of the Virgin Islands. CFVI funds several programs and initiatives including Voices for Virgin Islands Children whose mission is to promote the well-being of and empower children, youth and families in the US Virgin Islands through research, media outreach, public education and legislative advocacy. In addition, it seeks to involve the community as non-partisan, nonprofit advocates for children's needs and rights. The mission of The Fatherhood Collaborative is to foster increased recognition of the importance of responsible fatherhood in the lives of children, youth and families in the U.S. Virgin Islands. In a variety of ways, the Foundation has focused on issues related to fatherhood and has provided leadership in a number of different fatherhood-related efforts. The KIDS COUNT USVI Data Book provides information on child well-being in the U.S. Virgin Islands. Its purpose is to promote dialogue on children's issues, and to stimulate community response to improve the health, safety and economic status of VI children, from birth to age eighteen. USVI KIDS COUNT is part of a national initiative, sponsored by the Annie E. Casey Foundation, to create a detailed community-by-community picture of the condition of children nationwide. Since 2000, the KIDS COUNT USVI Data Book has been compiled and published each year by the Community Foundation of the Virgin Islands (CFVI), serving the needs of the territory's children, youth, and families. Another initiative, The Family Connection (FTC) has built a cutting edge resource library with more than 250 professional titles on early literacy, curriculum, child psychology, and the business management of child care centers. Additionally, TFC center offers a lending library with more than 1,000 developmentally appropriate toys and children's books. Over 150 parents, child care providers, teachers and university students are regular visitors to the TFC Center. TFC is the leader in early child care professional development, providing early childhood social and emotional workshops as well as early literacy workshops in the USVI territory. TFC also frequently reaches out to community groups to provide training by request. The TFC Center has become an important space for the early childhood community to gather and share ideas on raising the standard for high-quality care in the U.S. Virgin Islands. TFC has expanded its services with weekend and evening hours, an increase in staff, and a new center in development on St. Croix. TFC continues to reach out to the early childhood community by offering impact grants of up to $5,000 for early childhood education initiatives.
/2009/ Community Foundation of the Virgin Islands (CFVI): CFVI was created to serve both donors and nonprofit organizations of the Virgin Islands that want to ensure the highest quality of life for both present and future generations. Its primary goal is to build a collection of permanent funds, which will be used to enhance the educational, physical, social, cultural and environmental well-being of the children, youth, and families of the VI. CFVI funds several programs and initiatives including Voices for Virgin Islands Children whose mission is to promote the well-being of and empower children, youth and families in the US Virgin Islands through research, media outreach, public education and legislative advocacy. //2009//

***/2010/ The Family Connection (TFC) introduced Born Learning, a public engagement campaign focused on the importance of early learning for young children. The goal of Born Learning is to make lasting community change through building public awareness, education and community action. Born Learning was created by the national United Way, and is endorsed by our local United Way agencies. TFC produced three localized Born Learning radio spots to teach parents how to make every day moments learning moments. TFC staff has made guest appearances on radio shows to spread the word and***

***raise awareness about the importance of Born Learning in the community. TFC has also made Born Learning presentations and distributed learning materials Territory-wide at professional development and parent orientations. TFC is expanding the Born Learning campaign to businesses, private childcare centers, and doctors offices. //2010//***

State Systems Development Initiative, ( SSDI ) grant is focused on the Title V MCH Block Grant Health Systems Capacity Indicator #9(A) which is addressed through six project objectives:1) improve access to data linkages between birth records and Medicaid files; 2) create data linkages between birth records and WIC eligibility files; 3) obtain access to hospital discharge data; 4) increase analysis of data from the Youth Risk Behavior Survey(YRBS); 5) monitor opportunities for establishment or improvement in priority data linkages and access to priority data sets that are unable to be addressed in the current project period;and 6) provide quality data for MCH Block Grant performance measures and five-year needs assessment. To date the goals of this indicator are not realized due to technical and staffing challenges within the DOH system. SSDI funds will be utilized for collecting, analyzing, presenting and interpreting much of the data needed for the five year MCH Block Grant needs assessment. /2008/ The program does not receive SSDI funds. All data linkage activities are funded by the Block Grant. //2008//

Medicaid Program: Medicaid is authorized under Title XIX of the Social Security Act of 1935, as amended by P. L. 89-97 and is administered at the federal level by the Health Care Financing Administration. In the VI, Medicaid is administered by the Department of Health, the designated single State agency. The VI State Plan for Medical Assistance was approved by the Department of Health and Human Services (formerly Health, Education and Welfare) and has been in operation since 1966. The mission of Medical Assistance Program (MAP) is to assure that health care is readily available and accessible to all eligible low income persons and that the care is of high quality, comprehensive and continuous. To fulfill this mission, the Program must: assure that clients have access to necessary medical care; assure that the quality of care meets standards; promote appropriate use of services by clients; promote appropriate care by service providers; and assure that services are purchased in the most cost-effective manner.

The VI Medicaid Program is the central source of health care for the Virgin Islands' most vulnerable residents: the aged, blind, disabled and low income families who cannot afford to pay for their own health care expenses. As the payor of last resort, the MCH & CSHCN Program is fiscally linked to MAP. MAP functions under a $6,080,000 (cap) for fiscal year 2002 and a ratio of Federal and Local matching of 50/50. Mandatory Medicaid services include inpatient hospital, outpatient hospital, health clinic services, laboratory & x-ray services, Early & Periodic Screening, Diagnostic & Treatment (EPSDT), Family Planning, nursing home and physician services that must be pre-authorized, and Dental services. Optional services (but covered) include: optometrist services, eyeglasses, prescribed drugs, air transportation, and respiratory therapy. Optional services (not covered) include: services in institutions for mental illness, hospital transfer/air ambulance transportation, dentures, prosthetic devices, physical and occupational therapy, and/or durable equipment.
A revised Statement of Agreement to Ensure Maximum Collaboration and Utilization of the MCH & CSHCN Program under the VI State Plan for Medical Assistance has been executed by the Commissioner of Health and the Program Directors for MCH & CSHCN and MAP. This collaborative agreement provides for the coordination of care and services available to low-income populations served under Title V and Title XIX and was last revised in Fiscal Year 1999-2000. Efforts will continue in FY 2006 to revisit and update based on current identified needs. Assistance in applying for Medicaid is provided to users of Title V services through social workers at the MCH & CSHCN facilities. Social workers inform clients of all documents required at the time of registration, i.e. birth certificates, passports, naturalization papers, location of MAP offices, hours of operation, and how to apply. Potentially eligible MAP patients are identified at a variety of sites including outpatient ambulatory facilities, hospital facilities, and other government agencies such as the Department of Human Services. Patients who are low-income, uninsured, pregnant, or have special health care needs are referred to Social Services or the MAP offices directly for eligibility determination.

***/2010/ VIDOH remains unable to assure access to adequate health care for the Medicaid eligible population due to the statutory cap on federal Medicaid funds to the territory. These limitations continue to prevent the V.I. government from meeting the health care needs of all its Medicaid eligible residents. //2010//***

Child Health Insurance Program: Title XXI of the Social Security Act was enacted August, 1997 and provides 24 billion dollars over five years to insure millions of American children in families at or below 200% of poverty for children not eligible for Medicaid or other public or private insurance. The Title XXI legislation appropriated .25% of the total FY=98 budget for all territories amounting to $10,687,500, of which 2.6% was appropriated for the Virgin Islands. The Child Health Insurance Program, CHIP, is administered by the Bureau of Health Insurance and Medical Assistance. The Child Health Insurance Program Plan, which has been approved by the Centers for Medicare and Medicaid (CMS), allows for payment of unpaid medical bills for Medicaid patients less than 19 years of age. This waiver was allowed by CMS because Congress did not approve enough CHIP monies for the territories that would have allowed them to have a regular Child Health Insurance Program. In FY2004, the CHIP allotment was $1,629,435. These limited funds were used to pay already incurred medical bills for Medicaid children whose federal Medicaid funding ran out by the end of the year. Because many states were unable to spend their CHIP allotments, the unspent monies were redistributed which benefited the territories. However, a full fledged CHIP program is not established in the Virgin Islands due to lack of appropriate funding.
/2007/ Historically, MAP has been considered a health care financing system -- its role was to pay providers' claims. MAP has now grown into a program concerned with health outcomes, continuity of care, providers' satisfaction and appropriate access to care.
/2008/ BHIMA was forced to take cost-cutting measures to help combat the escalating obligations to medical assistance providers, caused by increased eligible participants, increased cost of service, and pharmaceuticals especially on the island of St, Croix. VIDOH instituted changes in Medicaid under a nationwide push to streamline the program.
***/2010/ Due to the limitations of the statutory cap and inadequate funding levels, VIDOH has been unable to address the health care needs of uninsured children. Limited S-CHIP funds are combined with MAP to provide health care for Medicaid eligible children. MAP funding in the territory is evaluated based on household income and is not age specific. To qualify, children must reside in a household with annual income less than $9,500 per year (family of 4) which is less than half of the federal poverty level. Even by combining these funding sources, the VI is unable to provide health care assistance to all eligible children in this very low income range. //2010//***

## F. Health Systems Capacity Indicators

**Introduction**

The Title V Guidance requires all States and jurisdictions to report annually on selected Health System Capacity Indicators (HSCI) that assess the capacity of the health care system to address the needs of the MCH population. Since these HSCI's measure services provided through Medicaid, SCHIP and SSI, it must be noted that allotments to the VI are capped and SSI is not available. The current system does not have an adequate data and information structure to obtain valid, reliable data to respond to these indicators. The VIDOH is moving towards providing a data system that integrates the data for patients' referrals, treatment, data sharing, and vital statistics reporting and also meets the needs of the various public health programs within the department.
/2008/ An integrated data system is not in place. The program remains without access or linkage to the Medical Assistance database or reports.//2008//
/2009/ Lack of data system remains unchanged. //2009//
***/2010/ An integrated data system has not been realized. The availability of information based on validity accuracy and measurability, remains unattainable. Data is obtained for most of the HSCI's through a variety of sources including the DOH Health Statistics, STD/HIV Program, hospital admission records, Office for Highway Safety, and VI-EMS.***

***The Title V program continues to provide preventive and primary care services for the MCH and CSHCN populations; despite the lack of data linkages. Improvement of existing linkages and surveillance systems to enhance data capacity remain a priority so that disparities can be identified, and efforts tailored towards specific populations and areas in greatest need; so as to further progress in improving strategies that address those needs. //2010//***

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 59.8 | 214.4 | 151.9 | 65.5 | 68.9 |
| Numerator | 49 | 158 | 112 | 52 | 47 |
| Denominator | 8188 | 7371 | 7371 | 7937 | 6823 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**
Denominator obtained from 2006 VI Household Survey, UVI Eastern Caribbean Center.
Numerator obtained from both hospitals denoting in-patient admissions with an average length of stay of 2.5days.

**Notes - 2007**
Denominator obtained from 2005 VI Household Survey, UVI Eastern Caribbean Center.
Numerator obtained from both hospitals denoting in-patient admissions with an average length of stay of 2.6 days.

**Notes - 2006**
Hospital admission data available from Gov. Juan F. Luis Hospital on St. Croix only.
Data received from Roy L. Schneider Hospital on St. Thomas shows 71 ED visits and 40 admissions. Average length of stay was 2.7 days.

**Narrative:**
#01 - The rate of children hospitalized for asthma (10,000 children less than five years old).

The Title V Guidance requires all States and jurisdictions to report annually on selected Health System Capacity Indicators (HSCI) that assess the capacity of the health care system to address the needs of the MCH population. Since these HSCI's measure services provided through Medicaid, SCHIP and SSI, it must be noted that allotments to the Virgin Islands are capped and SSI is not available. The current system does not have an adequate data and information structure to obtain valid, reliable data to respond to these indicators. The VIDOH is moving towards providing a data system that integrates the data for patients' referral, treatment, data sharing, and vital statistics reporting and also meets the needs of the various public health programs within the department.
/2008/ An integrated data system is not in place. The program remains without access or linkage to the Medical Assistance database or reports. Pulmonology services were not available this fiscal year. Juan F. Luis Hospital on St. Croix showed a slight increase of in-patient admissions over FY '05. In FY'06 92 patients were admitted to the ED with 80 admissions to the Pediatrics Unit. Average length of stay was 3.4 days. A family asthma education plan was initiated. This

was curtailed due to a lack of financial resources. Families were referred to a pediatric allergist-immunologist on-island. Nursing staff on both islands received in-service education on the components of the asthma education and continues to work with parents and families of children with asthma to increase awareness of environmental triggers, increase early sign recognition and encourage proper management of asthma. This includes avoidance of tobacco use around young children and in the home. According to the VI Chapter of the American Lung Association, historically the VI has a low percentage of individuals using tobacco. Data from the 2006 YRBS shows that cigarette use among 9-12 graders is less than 10%. The MCH Program has obtained the New York State Asthma action plan for parents and clinical management materials for nurses and pediatricians to use in their education of parents //2008//

/2009/ Staff physicians and nurses continue to educate families on importance of nutrition, healthy eating practices and habits, impact of both first and second-hand smoking, avoidance of environmental and household asthma triggers and other allergens, and appropriate management and treatment of early symptoms to avoid complications. Pulse oximeters and aerosol nebulizers are available in both clinic sites for immediate treatment of children with signs of distress. This availability decreases the need for emergency department visits and in-patient admissions. There were 46 in-patient admissions in both hospitals with an average length of stay of 2.7 days. The VI Chapter of the American Lung Association (VI-ALA) in collaboration with VIDOH and Department of Education was awarded funding from the Office of Minority Health for three years to organize and conduct asthma summer camps in each district starting in July 2008. Each of these two week camps will be staffed by a physician, three school nurses, a school psychologist and respiratory therapist. //2009//

***/2010/ Asthma remains a significant public health challenge in the territory, and an area where methods to collect and analyze data more effectively is critical. The rates for emergency department and inpatient admissions due to asthma in this population vary widely. The Juan F. Luis Hospital on St. Croix reported 342 ED admissions while the Roy L. Schneider Hospital on St. Thomas reported 84 ED admissions in FY 2008. Inpatient admissions with a primary diagnosis of asthma were 37 and 10 respectively. The average length of stay was 3.3 days on St. Croix and 1.8 days on St. Thomas. This variation in patient statistics demonstrates the need to identify strategies that include expanding and evaluating data collection to better estimate the prevalence and morbidity of asthma; and to look at asthma incidence, severity, mortality, management, and cost. The outcome would be the development and implementation of a sustainable action plan to expand and improve the quality of asthma education, prevention, management, and services. Children with asthma who are unable to gain access to primary care or prescription medications due to uninsured or underinsured status are at a greater risk of needing hospitalization. Therefore, appropriate asthma management in young children is a primary focus of this program with the ultimate goal of decreasing emergency room visits of young children for asthma related complaints, and to improve the lives of those who live with asthma. Pulse oximeters and aerosol nebulizers are available in both clinic sites for immediate treatment of children with signs of distress.***

***The Title V program will continue to collaborate with the VI Chapter of the American Lung Association to foster better awareness of asthma; and to provide asthma education to health professionals, school personnel and other key individuals who provide services to this population. Additionally, an Asthma Care protocol and plan of action for both home and school, based on NIH National Heart, Lung, and Blood Institute (NHLBI) and the New York State Asthma Plan, is being developed. //2010//***

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 0.0 | 12.4 | 13.9 | |
| Numerator | 0 | 0 | 218 | 247 | |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | 1670 | 1676 | 1760 | 1772 | |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | |

**Notes - 2008**
Data for this measure is not available or collected by the Bureau of Health Insurance and Medical Assistance.

**Notes - 2007**
Data for this measure is not available or collected by the Bureau of Health Insurance and Medical Assistance.

**Notes - 2006**
Data for this measure is not available or collected by the Bureau of Health Insurance and Medical Assistance.

**Narrative:**
#02 -The percent of Medicaid enrollees whose age is less than one year who received at least one periodic screen.
The Early Periodic Screening, Diagnostic and Treatment (EPSDT) program provides well-child and comprehensive pediatric care for children and adolescents through age 20. Medicaid data systems in the territory lack the capability to provide specific data relating to periodic screening in this section. This data is not available from the Medicaid program. The MCH & CSHCN Program lacks access to the paid claims files.
/2008/ Based on data provided by clinic staff for FY 2006, 29% of children less than one year (218 out of 755) received at least one screen. This data reflects only children seen in both districts who were covered by Medical Assistance at the time of the visit. Paid claims documentation is unavailable from the MAP Program. The actual number of eligible children is unknown as the MAP data system does not provide this information. //2008//
/2009/ The EPSDT periodicity schedule is used for all children receiving services at both MCH clinic sites. Paid claims data is not available from the MAP program. Estimated clinic sites data shows that 40 % of children territory-wide have Medical Assistance while 52% are uninsured. Due to the stringent requirements for household income many families and children who are eligible for MAP are not certified. The MCH Program will continue to support delivery of preventive health services, such as health screenings and immunizations; refer uninsured infants and children seen in the clinics for determination of Medicaid eligibility; and encourage collaboration between Title V and the Medical Assistance to ensure that EPSDT services are provided to all eligible or certified children.//2009//

***/2010/ Parent education on EPSDT services is not provided to families at the time of certification by the Medical Assistance Program. Therefore, the Title V program has undertaken the initiative to train staff, both clinical and administrative, to provide information to parents who access the health care system through MCH clinics regarding the preventive and treatment services and supports that are available to them. The status of the MAP program's ability to report paid claims data remains unchanged. Data is not collected or reported from CMS Form 416. //2010//***

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Numerator | 0 | 0 | 0 | 0 | 0 |
| Denominator | 1670 | 1676 | 1760 | 1772 | 1842 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

**Notes - 2008**
Data for this measure is not available or collected by the Bureau of Health Insurance and Medical Assistance.
The Child Health Insurance Program Plan, which has been approved by the Centers for Medicare and Medicaid (CMS), allows for payment of unpaid medical bills for Medicaid patients less than 19 years of age. This waiver was allowed by CMS as Congress did not approve enough CHIP monies for the territories that would have allowed them to have a regular Child Health Insurance Program.
Denominator obtained from the number of live birth admissions.

**Notes - 2007**
Data for this measure is not available or collected by the Bureau of Health Insurance and Medical Assistance.

**Notes - 2006**
Data for this indicator is not available from the Bureau of Health Insurance and Medical Assistance.
The Medical Assistance Program received a waiver from CMS to use SCHIP funds to supplement acute care for children eligible for MAP.
This is due to the Medicaid cap in the territory which limits available Medicaid or SCHIP funds for eligible families.

**Narrative:**
#03 - The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

This HSCI is not applicable to the V.I. due to the Medicaid Cap. The Child Health Insurance Program, CHIP, is administered by the Bureau of Health Insurance and Medical Assistance. The Child Health Insurance Program Plan, which has been approved by the Centers for Medicare and Medicaid (CMS), allows for payment of unpaid medical bills for Medicaid patients less than 19 years of age. This waiver was allowed by CMS as Congress did not approve adequate Child Health Insurance Program (CHIP) monies for the territories that would have allowed a regular Child Health Insurance Program.

/2008/ This waiver remains in effect. Though SCHIP funds have been increased to the territory, they continue to be utilized only for acute care for children who are covered by Medical Assistance.//2008//

/2009/ SCHIP funds are used as an expansion of the Medicaid Program for children in certified households. Service utilization data is not available for MAP enrollees at this time.//2009//

***/2010/ Due to the limitations of the statutory cap and inadequate funding levels, VIDOH has***

***been unable to address the health care needs of uninsured children. Limited S-CHIP funds are combined with MAP to provide health care for Medicaid eligible children. Service utilization and eligibility data is not available from the program. //2010//***

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 41.1 | 40.7 | 44.9 | 39.9 | 15.7 |
| Numerator | 687 | 686 | 787 | 706 | 290 |
| Denominator | 1672 | 1686 | 1752 | 1771 | 1844 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**
Data for CY 2008 obtained from DOH Office for Vital Records & Statistics. This is partial data and reflects approximately 33% of birth certificates evaluated and edited.

**Notes - 2007**
Data obtained from Bureau of Health Statistics is incomplete and reflects the first three quarters of CY 2007.

**Narrative:**
#04 - The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent of the Kotelchuck Index.

/2008/ According to preliminary data provided by the Bureau of Health Statistics for calendar year 2006 38.5.9% of women (677out of 1760) entered prenatal care in the first trimester and had at least the minimum number of visits recommended for adequate prenatal care. This is a slight decrease from the same period in 2005 (2.1%). The number of women enrolling in prenatal care in the first trimester in DOH Prenatal Clinic and Frederiksted Health Center both on St. Croix (53%). This data is unavailable for the St. Thomas-St. John district. Outreach activities are on-going to high or at-risk pregnant women in low-income, underserved communities by VI Perinatal, Inc. (VIPI) outreach staff and case managers who encourage women to seek care early and continuous care to guarantee the best possible outcome for delivery. An on-going awareness campaign by VIPI also stresses the importance of adequate prenatal care in preventing preterm births and poor birth outcomes. //2008//
/2009/ The Office of Health Statistics and Vital Records Registry is unable to provide complete data at the time of this report. Based on partial data for calendar year 2007 it is estimated that 40.9% of women had an adequate number of prenatal visits. This data covers the first three quarters of CY2007. Data provided by DOH prenatal clinics estimate that 31% of women (n=732) enrolled in prenatal care in the first trimester, with 37% in the second and 26% in the third; 6% were not reported or unknown. Data from both 330 centers is not included. //2009//

***/2010/Several factors influenced the program's ability to maintain and/or improve this HSCI***

***this fiscal year. The main factor is the lack of sufficient OB (MD's, CNM's or CNP's) providers to offer the level of service required to ensure early enrollment and adequate visits. Other factors are barriers such as not being able to get appointments until into the second or third trimester, not enough money or no health insurance, and the lack of transportation. The birth rate has increased by approximately 5% since 2006 (1752 to 1844). There has also been an increase in demands for prenatal services by women who are either unemployed, under or uninsured, or are working poor; not being eligible for Medical Assistance (MAP,) they are thus considered self-pay. The restriction of MAP guidelines for U.S. citizens or legal residents of more than 5 years also excludes the growing population of undocumented women. This creates difficulty in receiving early and adequate prenatal care due to the lack of a payment source; leading many to enter care in the third trimester or not at all.***
***Data provided by the MCH Prenatal Clinic on St. Croix shows that 37% (151 of 404) of women entered care in the first trimester. The final report for the territory shows that in 2007 39.9% of women overall entered care in the first trimester.***
***There are no safety net providers, initiatives or programs available territory-wide that promote support services such as transportation and care coordination to ensure regular and adequate care. V.I. Perinatal Inc., has undertaken a social marketing campaign to encourage early prenatal care and provide case management and outreach services for 243 women and their families in FY 2008.***
***Birth certificate data is used to calculate this index. The VI does not participate in PRAMS or any other data/statistical collection and analysis effort to calculate the adequacy of prenatal care in all populations. //2010//***

**Health Systems Capacity Indicator 07A:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 54.8 | 30.0 | 30.0 | |
| Numerator | 0 | 7785 | 1989 | 1698 | |
| Denominator | 14210 | 14210 | 6630 | 5663 | |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | |

**Notes - 2008**
Data not available or collected for this indicator by the Bureau of Health Insurance and Medical Assistance.
Estimates based on children seen in both districts with Medical Assistance coverage.

**Notes - 2007**
Data not available or collected for this indicator by the Bureau of Health Insurance and Medical Assistance.
Estimates based on children seen in both districts with Medical Assistance coverage.

**Notes - 2006**
Data not available or collected for this indicator by the Bureau of Health Insurance and Medical Assistance.

**Narrative:**
#07A - The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

/2008/ /The MAP data system currently does not have the capability to generate specific claims data related to children and the services received. The Medical Assistance Program (MAP) functions under a cap for fiscal year 2006 and a ratio of Federal and Local matching of 50/50.

/2009/ Medicaid funds allotted for USVI are capped and insufficient to provide services for all Medicaid eligible children and families. It is challenging to provide an accurate estimate of the number of children who received services paid by Medicaid funds. Medicaid is accepted at the government run health facilities. There are a limited number of private providers that accept Medicaid as a form of payment. This presents a unique challenge in reducing health disparities in that Medicaid clients cannot access the health care available in the private clinics. The MCH Program will continue to provide Medicaid enrollees or potentially eligible enrollees access to health care service regardless of insurance status. //2009//

***/2010/ Status of this HSCI remains unchanged. //2010//***

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | NaN | 3.9 | 7.5 | 24.7 | 26.9 |
| Numerator | 0 | 65 | 126 | 445 | 606 |
| Denominator | 0 | 1681 | 1674 | 1798 | 2251 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**
Data obtained from Division of Dental Services St. Thomas-St. John District..
Denominator is actual # of children receiving services.
Numerator is # of children age 6-9 years who received any service, including school based screening.

The Medical Assistance Program does not collect age specific claims data.

**Notes - 2007**
Data obtained from Division of Dental Services St. Thomas-St. John District..
Denominator is actual # of children receiving services.
Numerator is # of children age 6-9 years who received any service.

The Medical Assistance Program does not collect age specific claims data.

**Notes - 2006**
Data obtained from Division of Dental Services, reflects services provided in both districts including school based screening (elementary level) on St. Croix.
Numerator is # of children age 6-9 years who received sealants. Data provided by Dental Services.
The Medical Assistance Program does not collect or report age specific claims data.

**Narrative:**
07B - The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

/2008/ Dental sealants were provided to the Division of Dental Health in both districts. A total of 126 children received application territorially. In the St. Thomas-St. John district this equaled 13% of children receiving exams (82 out of 628). 44 children received application on St. Croix. The total number receiving exams is not available. Data by age, ethnicity or insurance type is not collected. The Medical Assistance program does not collect or report this data. //2008//

***/2010/ In the St. Thomas-St. John District a total of 2,251 children received dental services. 1,544 were screened and fluoride treatments provided in the school setting for kindergarten, fifth and ninth graders. 606 children received sealants, with 945 receiving prophylaxis through the Dental Clinic on St. Thomas. DOH MIS-HealthPro database reports that a total of 532 children in the 6-9 years age group with Medicaid received services in both districts. The Medical Assistance program does not collect or report this data applicable to this or any HSCI. //2010//***

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Indicator | NaN | | | | |
| Numerator | 0 | | | | |
| Denominator | 0 | | | | |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | | |

**Notes - 2008**
This HSCI is not applicable to the Territory of the Virgin Islands.

**Notes - 2007**
This HSCI is not applicable to the Territory of the Virgin Islands.

**Notes - 2006**
Territory of the USVI residents are not eligible for SSI.

**Narrative:**
08 - The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services for the State CSHCN Program.

This HSCI is not applicable to the V.I. SSI benefits are not available to children in this age group with disabilities. Rehabilitative services are provided through the Department of Education Special Education Program and the MCH & CSHCN Program.

## Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

| INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | YEAR | DATA SOURCE | POPULATION | | |
|---|---|---|---|---|---|
| | | | MEDICAID | NON-MEDICAID | ALL |
| Percent of low birth weight (< 2,500 grams) | 2008 | other | 3.5 | 10 | 13.5 |

**Notes - 2010**
The other data sources include:

MCH Prenatal
St. Thomas East End Medical Center
Vital Records

The Medical Assistance Program is not required to report information in this format to CMS, therefore it is not collected.

The data for calendar year 2008 from the Office of Vital Records and Statsitics is incomplete, and only reflects 33% of the records for birth certificates which have been evaluated and edited.

**Narrative:**
#05A - Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State- Percent of low birth weight < 2,500 grams.

/2008/ According to data estimates from the Bureau of Health Statistics for calendar year 2006, 8.8% of live births were below 2500 grams. This compares to 10.7% in the same period for 2005. This may be directly due to outreach activities to high or at-risk pregnant women in low-income, underserved communities by VI Perinatal, Inc. (VIPI) outreach staff and case managers who encourage women to seek care early and continuous care to guarantee the best possible outcome for delivery especially in low-income underserved communities. An on-going awareness campaign by VIPI also stresses the importance of preventing preterm births and poor birth outcomes. The population known to be below the federal poverty level is presumed eligible for Medical Assistance. However, the poverty threshold for annual allowable income to qualify for Medicaid in the VI is $9,500 for a family of five compared to the national average of $23,497 (Census Bureau 2004) for a family of five. This requirement causes difficulty for uninsured families to qualify for Medical Assistance and creates barriers to health care resources and services. These uninsured individuals are generally unable to afford health insurance premiums and therefore not as likely to seek early prenatal care which may contribute to poor birth outcomes. The actual cost of providing Medicaid services to this population who would otherwise meet eligibility criteria is unknown. Government programs, clinics and hospitals (2) provide health care services at little or no cost, everyone, including low income, uninsured or underinsured individuals and families have access to essential services. Prenatal patients with Medicaid

coverage do not have the ability under program requirements to access care at private providers which limits their choices of providers. VIPI instituted the Perinatal Morbidity & Mortality Review Committee to determine the common clinical indicators leading to preterm births and fetal deaths. Data is being collected by the committee for analysis. //2008//
/2009/ Preliminary data from the Bureau of Health Statistics for the first three quarters of CY 2007 estimates that 12.5% of live births weighed less than 2500 gms. Should this trend continue it would signify an increase of at least 2.3% from CY 2006 for which the final report was 10.2%. Prenatal clinic providers continue to offer health education and counseling to pregnant women with complex medical and social risk factors associated with preterm and low birth weight infants. VIPI continues outreach and case management services for high-risk pregnant women. //2009//

***/2010/ Final data for CY 2007 shows that 11.6% of births were less than 2500 grams. Though complete data is not available for CY 2008, estimates are 3.4%. There is no valid data source available to compare the outcomes for Medicaid / non-Medicaid and all MCH populations. Medicaid records are not linked to Birth Certificate/Death Certificate records. This needed linkage would address the challenges of accessing and reporting accurate data in a timely manner; and by monitoring increases and decreases in the utilization of Medicaid services. However, the impact of the Medicaid Program is restricted as it does not operate under assumption of presumptive eligibility, rather it is guided by an imposed cap. As a result, case management/care coordination and other intervention strategies such as home visiting services are not covered. //2010//***

## Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Infant deaths per 1,000 live births | 2008 | other | 2.2 | 4 | 6.2 |

**Notes - 2010**
The other data sources include:

MCH Prenatal
St. Thomas East End Medical Center
Vital Records

The Medical Assistance Program is not required to report information in this format to CMS, therefore it is not collected.

The data for calendar year 2008 from the Office of Vital Records and Statsitics is incomplete, and only reflects 33% of the records for birth certificates which have been evaluated and edited.

**Narrative:**
#05B- Comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State - Infant deaths per 1,000 live births.

/2008/ There are no significant changes to this indicator. Data estimates from the Bureau of Health Statistics shows a 3.4% mortality rate for 2006. This is a 1.3% decrease from the same period in 2005. Health Statistics does not collect or report insurance data on the birth certificate form. It is anticipated that the electronic birth records database in process of being purchased by

DOH will provide this information in the future. //2008//
/2009/ The final infant mortality rate for 2006 is reported at 4.5%. Preliminary report for the first three quarters of CY 2007 show an increase to 7.5%. The electronic birth records database is not a reality. The territory lacks a MCH Epidemiologist who would be available to conduct analysis of infant deaths to identify groups at highest risk and to identify risk factors. Results from these analysis would potentially be used to target intervention efforts in communities with the highest rates of infant death and to focus efforts on effective interventions. VIPI has taken the lead role in collaboration with both hospitals Ob-GYN, Perinatology, Neonatology, Labor & Delivery and DOH staff to perform a seven year chart review looking at indicators for preterm, low-birth weight, and infant mortality. It is anticipated that a draft will be available in Spring 2009. //2009//

***/2010/ Low birth weight and preterm birth continue to be the leading risk factors for infant mortality and morbidity. DOH Vital Statistics reported the final infant mortality rate for 2007 at 6.8% compared to 4.5% in 2006. VIPI continues to lead the effort to implement a management information system to identify trends related to fetal and infant deaths. The program has contracted a chart auditor who is currently conducting audits at Juan F. Luis Hospital on St. Croix. Medical records for births 2500 grams or less are being reviewed to determine contributing factors to infant mortality, preterm or low birth weight. Medicaid claims or hospital discharge data is not available for comparison of Medicaid/non-medicaid population outcomes. //2010//***

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester | 2008 | other | 23 | 34 | 52 |

**Notes - 2010**
The other data sources include:

MCH Prenatal
St. Thomas East End Medical Center
Vital Records

The Medical Assistance Program is not required to report information in this format to CMS, therefore it is not collected.

The data for calendar year 2008 from the Office of Vital Records and Statsitics is incomplete, and only reflects 33% of the records for birth certificates which have been evaluated and edited.

**Narrative:**
#5C -The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State - Percent of pregnant women entering care in the first trimester.

/2008/ The Bureau of Health Statistics provides data for this measure. The MCH & CSHCN

Program does not have direct access to the data. Estimates are provided based on prenatal patients who accessed care at public facilities and does not include women who received care at private providers. According to the data provided to the program 57% (996 of 1760) of infants were born to women receiving prenatal care. The Medical Assistance program does not have the ability to provide accurate data on paid claims for prenatal patients. //2008//

/2009/ There are no significant changes to this indicator with the exception that the final report for CY 2006 shows that 66.2% (1167 of 1763) were born to women who received prenatal care beginning in the first trimester. Preliminary data for the first three quarters of CY 2007 show 61.2%. //2009//

***/2010/Based on the final report for CY 2007, 62.6% (1109 of 1771) were born to women who received prenatal care beginning in the first trimester a decrease of 3.6% from the previous year. The Medical Assistance program (MAP) does not have the ability to provide prenatal care utilization, therefore a comparison between medicaid and non-medicaid population is not possible. //2010//***

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

| **INDICATOR #05** ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*** | **YEAR** | **DATA SOURCE** | **POPULATION** | | |
|---|---|---|---|---|---|
| | | | **MEDICAID** | **NON-MEDICAID** | **ALL** |
| Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]) | 2008 | other | 10.6 | 35 | 45.6 |

**Notes - 2010**
The other data sources include:

MCH Prenatal
St. Thomas East End Medical Center
Vital Records

The Medical Assistance Program is not required to report information in this format to CMS, therefore it is not collected.

The data for calendar year 2008 from the Office of Vital Records and Statsitics is incomplete, and only reflects 33% of the records for birth certificates which have been evaluated and edited.

**Narrative:**
#5D -The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State - Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]).

/2008/ Barriers to accessing early prenatal care include lack of providers at public facilities, inability to access private providers, and lack of insurance coverage public or otherwise. VI does

not participate in PRAMS, therefore all data is obtained from the Bureau of Health Statistics, which does not collect insurance data. The Medical Assistance program does not collect or report required data for this measure. //2008//

/2009/ This was addressed under HSCI # 4. There are no significant changes to report. //2009//

***/2010/ See discussion under HSCI #4. There are no major changes to report. //2010//***

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
|---|---|---|
| Infants (0 to 1) | 2008 | 200 |
| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Infants (0 to 1) | 2008 | 200 |

**Narrative:**
#06A - The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0-1).

Due to the federal Medicaid cap which severely restricts provision of services to all eligible families, eligibility is determined at 200% of poverty level.
The federal Medicaid cap remains in place. There are no indications that Congress will change or increase this in the near future.

/2008/ The Medicaid cap imposed by Congress remains in place. There is little likelihood that this status will change. //2008//

/2009/ The Virgin Islands as a territory receives Medicaid funds at a lower rate than the States. Due to the federal Medicaid cap which severely restricts provision of services to all eligible families, eligibility is determined at 200% of federal poverty level. An effort to raise the ceiling on the territory's funding level is a mission undertaken, at the national level, by the Virgin Islands Delegate to Congress. There are no indications this will change. The MCH Program, will continue reaching out to infants, children and families without health care insurance and referring them to the Medicaid Program to undergo an evaluation to determine eligibility. //2009//

***/2010/ Due to the federal Medicaid cap, which severely restricts the provision of services to all eligible families, eligibility is determined at 200% of poverty level. There are no indications that Congress will change or increase this in the near future. Eligibility requirements for Medicaid and SCHIP also remain unchanged from the previous years' discussion. //2010//***

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
|---|---|---|

| | | |
|---|---|---|
| Medicaid Children<br>(Age range 1 to 5)<br>(Age range 5 to 14)<br>(Age range 15 to 21) | 2008 | <br>200<br>200<br>200 |
| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Medicaid Children<br>(Age range 1 to 5)<br>(Age range 6 to 14)<br>(Age range 15 to 21) | 2008 | <br>200<br>200<br>200 |

**Narrative:**
#6B -The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children.

/2008/ The waiver for SCHIP remains in effect. Though SCHIP funds have been increased to the territory, they continue to be utilized only for acute care for children who are covered by Medical Assistance. //2008//

/2009/ See discussion in HSCI #3 and #6A. //2009//

***/2010/ See discussion in HSCI # 3 and #6A. The waiver for SCHIP remains in effect. Though SCHIP funds have been increased to the territory, they continue to be utilized only for acute care for children who are covered by Medical Assistance. Children qualify for MAP only if they reside in an eligible household. //2010//***

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

| | | |
|---|---|---|
| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL Medicaid** |
| Pregnant Women | 2008 | 200 |
| **INDICATOR #06**<br>**The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.** | **YEAR** | **PERCENT OF POVERTY LEVEL SCHIP** |
| Pregnant Women | 2008 | 200 |

**Narrative:**
#6C The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women.

/2008/ See discussion in HSCI #5A, 5B & 5C. There is no change in this indicator. Poverty level is determined at 200% of federal poverty guidelines.//2008//

/2009/ Discussion on this indicator is unchanged. //2009//

***/2010/ Discussion on this indicator is unchanged. Eligibility is determined by household income. //2010//***

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

| DATABASES OR SURVEYS | Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3) | Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N) |
|---|---|---|
| ANNUAL DATA LINKAGES<br>Annual linkage of infant birth and infant death certificates | 1 | No |
| Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files | 1 | No |
| Annual linkage of birth certificates and WIC eligibility files | 1 | No |
| Annual linkage of birth certificates and newborn screening files | 1 | No |
| REGISTRIES AND SURVEYS<br>Hospital discharge survey for at least 90% of in-State discharges | 1 | No |
| Annual birth defects surveillance system | 1 | No |
| Survey of recent mothers at least every two years (like PRAMS) | 1 | No |

**Notes - 2010**

**Narrative:**
09(A)- The ability of States to assure that the Maternal and Child Health Program and Title V Agency have access to policy and program relevant information.
The MCH & CSHCN Program has the ability to access data via written request for program planning or policy purposes. Linkages with electronic databases that house the data are not yet available.

/2008/ There are no changes in this indicator. A web-based database system for data linkage based on National Center for Health Statistics reporting requirements is not complete. It is anticipated to be completed by December 2007. //2008//

/2009/ The web-based database system is complete and ready for initial testing. However, challenges with the DOH network have prevented any further action on completion of the database. //2009//

***/2010/ The status of this indicator remains unchanged. //2010//***

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

| DATA SOURCES | Does your state participate in the YRBS survey? (Select 1 - 3) | Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N) |
|---|---|---|
| Youth Risk Behavior Survey (YRBS) | 1 | No |

**Notes - 2010**

**Narrative:**
09(B)- The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.

/2008/ The 2005-2006 VI Youth Risk Behavior Factor Survey was jointly administered by the VIDOH Division of Mental Health, Alcoholism and Drug Dependency services and Department of Education utilizing funds from the State Incentive Grant (SIG). The survey sampling was administered to all classes of students in grades 9 through 12 at the 4 public high schools, 2 each on St. Croix and St. Thomas. And, the same for the 4 largest private/parochial high schools, 3 on St. Croix and one on St. John. Of the 3303 respondents, there were 3251 valid student surveys. And, 90% or 2919 were from the 4 public high schools, and 10% or 332 from the 4 private/parochial high schools.
Current cigarette use was very low compared to the US mainland. Use rates were higher among Hispanics and lower among 11th graders. These rates were all lower than 10% compared to 25% or higher on the mainland. VI students reported lower rates of first use of cigarettes before age 13, < 10%. Early cigarette use rates were higher among Hispanics (9.6%) compared to Blacks (5.6%). Daily cigarette use (at least on =20 of the past 30 days) was very rare among students. These rates were reported at < 1%. Heavy cigarette use (defined as more than 10 cigarettes per day) was more frequent in males at 62.7% over females at 52%. The highest use was 10th graders at 67.2% and Hispanics at 68.7%. On average, over half (57%) of adolescents who had smoked cigarettes during the past year reported stopping smoking for one or more days because they were trying to quit. Smokeless tobacco rates were also reported low at 1-2%. Smokeless tobacco use rates were also much lower, ranging from 1 to 2%. Students reported the past 30 days use for females at 0.9% and males at 0.6%. While, the highest rate 0.9%) was 10th graders and 1.0% for Hispanics.
The desired outcome of this annual surveillance is to guide service providers as they identify, track, and better understand vital adolescent public health problems. This will also assist providers to develop and implement effective programs and policies to better serve the Territory's adolescent population. //2008//
/2009/ / The 2006-2007 VI Youth Risk Behavior Factor Survey was jointly administered by the VIDOH Division of Mental Health, Alcoholism and Drug Dependency services and Department of Education utilizing funds from the State Incentive Grant (SIG). The target group was 9-12 graders and the survey was administered in all public high schools (4) and 4 of the largest private/parochial schools. Current cigarette usage remain low at 2.8% compared to 23% on the U.S. mainland. Daily cigarette use remained at < than 1%. //2009//

***/2010/ YRBSS was not administered in 2007-2008 or 2008-2009 school years. The Title V Program plans to revise the upcoming adolescent health needs assessment to include items from this survey. //2010//***

# IV. Priorities, Performance and Program Activities

## A. Background and Overview

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES
ANNUAL REPORT / ANNUAL PLAN

A. Background and Overview

The Title V Maternal and Child Health Services Block Grant Program is operated as a single Administrative Unit within the Department of Health. The unit, headed by the Director of MCH & CSHCN, is responsible for conducting the statewide assessment of needs, agency management, program planning and implementation, policy development, and interagency collaboration. Within the Administrative Unit are Program Administrators on each island who supervise the financial and clinic management, and program activities.

In FY '07, MCH & CSHCN administered the following programs:
Preventive and Primary Child Health Care
Integrated newborn genetic/metabolic and hearing Screening
Prenatal Care Services and Care Coordination
Subspecialty Care Services

Throughout FY'07, the MCH & CSHCN Program employed strategies to promote care coordination and collaboration among programs serving the special needs population. Outreach, education and case management activities for pregnant women were provided through the expanded V.I. Perinatal Inc., (Promoting Healthy Families-HCAP and Healthy Families, Healthy Babies Initiative). Collaboration is on-going with the Department of Human Services in the implementation of the Child-Care Guidelines, a V.I. Stepping Stone Manual, Rules and Regulations for Child Care in the Virgin Islands. MCH staff were trained as child care health consultants.

Partners and collaborators who were actively engaged with the program to maximize sharing of resources included individuals from the Departments of Education, Labor, and Justice, 330-funded Community Health Centers, Medical Assistance Program, WIC Program, Vital Statistics, Immunization, Dental Health, Family Planning, Nursing Services, Adolescent Health Abstinence Education Program, Social Services, STD/HIV/TB, Infants and Toddlers Program, Community Partners, and Parent Advocates. Parent and consumer participation and involvement via the V. I. Alliance for Primary Care and the MCH Advisory Council were strengthened.

2008/ The MCH & CSHCN Program focuses on the well being of the MCH populations of women and infants, children and adolescents, and children with Special Health Care needs (CSHCN) and their families, through addressing the priorities identified in the 2005 needs assessment. The program places an emphasis on developing core public health functions and responding to changes in the health care delivery system. As a territory with significant shortages of pediatric medical services and limited existing services, the Virgin Islands faces many challenges to development of systematic approaches to population based direct care services. In the past few years, program activities addressed improvement of access to services low-income, underserved or uninsured families, identification of the needs of culturally diverse groups, especially non-English speaking and other immigrant groups, and recognition of changes brought about by lack of access to adequate health insurance coverage, public or private, for a significant percentage of the population. In addition, activities for children and youth with special health care needs focused on assuring pediatric specialty and sub-specialty services to children and families, integrating data systems, continuing collaborations with private and public partnerships, and integrating community-based services. //2008//

## B. State Priorities

IV-B. State Priorities

The Virgin Islands MCH & CSHCN has identified the following top ten (10) priority needs for primary and preventive care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for children with special health care needs.

•To increase certification and enrollment in family support programs and services.
•To facilitate and encourage family participation in transition planning.
•To improve and strengthen linkage of children with special health care needs and community-based support services.
•To promote community partnerships.
•To promote and advocate for the medical home concept as a standard of care to private and non-private health care providers.
•To provide continuous and on-going screening for CSHCN by expanding EPSDT screening standards.
•To review Medicaid reimbursements for key elements of the medical home including screening and care coordination.
•To improve access to prenatal care and reproductive health services leading to healthy birth outcomes.
•To improve access to primary and preventative health care services for all segments of the MCH population.
•To assure adherence to good nutrition standards and promote healthy lifestyle choices.

These identified needs are related to specific performance measures addressed by the program and are addressed on the four levels of the MCH pyramid.
2007/ As a result of the VI Title V needs assessment process, the Virgin Islands MCH & CSHCN selected ten (10) priority needs for primary and preventive care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for children with special health care needs. These were identified based on data analysis of the needs and evaluated for providing measurable data and outcomes. Some of the priorities identified in the previous five year assessment did not lend themselves easily to evaluation due to vague wording, lack of clear time lines and lack of identification of the target population being addressed. It is anticipated that during the remainder of fiscal year 2006 and throughout fiscal year 2007 modifications to these priority needs will occur.//2007//

/2008/ During the past fiscal year, a review of the six (6) Healthy People 2010 objectives under Focus Area 16 for Maternal, Infant and Child Health, which were selected by the program for performance and improvement was accomplished. This was performed in order to link the HP 2010 objectives where possible with the priorities and strategies identified in the 2005 Needs Assessment. Activities and strategies identified to address the stated priorities / needs are anticipated to have a positive impact on achievement of outcomes. //2008//

Issues related to access to care are addressed through provision of comprehensive primary and preventive care for children and adolescents which includes access to direct medical care; referrals to support programs and services; and strengthening of Title V collaborative partnerships. The Title V program continues to function as the safety net for families with limited resources. The program remains committed to providing clinical preventive care services for pregnant women, infants and children in low income populations.
Children with special health care needs have access to a source of care that provides evaluation and treatment sources; early developmental and hearing screening; early intervention services; care coordination and family support services, and access to clinical and laboratory services. Improvements in data systems for collection, analysis, surveillance and reporting capacity are critical to providing accurate assessments to assure these needs are met and the target

population is being served.

***/2010/ In retrospect, the U. S. Virgin Islands Maternal & Child Health and Children With Special Healthcare Needs (MCH & CSHCN) Program has persevered in the midst of environmental, social, and economical shifts at the local (VI) and national levels. This is most evident through the stability of cohesive linkages formed over the years with public and private affiliates, who are supportive and fixed on formulating a system of care under the Public Health arena that affords infants, children, youth, and young and older adults easy and affordable access to extensive healthcare services.***

***MCH Director recognizes the importance of continuity, and as a consummate professional in the Public Health arena, an advocate for women and children, and a partner to parents, caregivers, and practitioners, the major concern is that our target population has every opportunity to quality, expansive healthcare in the U.S. Virgin Islands. Furthermore, Sustainability is paramount, as the MCH & CSHCN Program remains the leading provider of affordable healthcare services for women, infants, children, and youth territory wide. Serving this population, at the Virgin Islands MCH & CSHN, are 20 public health professionals per 100,000 residents. This places the program in an unequally skewed position, when compared to the national average of 138 professionals. The most significant shortages are board certified or eligible primary care physicians, nurse practitioners, MCH epidemiologist, and experienced public health nurses.***

***Program Priority objectives linked to the Healthy People 2010 puts in place the development and expansion of the program's infrastructure utilizing local and national capabilities and resources. Fostering local and national support is most advantageous as attested by civic-engagement specialists, who stress the importance of avoiding isolation in any service delivery arena. MCH & CSHCN, in order to maximize broader support, has engaged the involvement of their Advisory Council, program staff, active volunteers (some will be young people), youth-related community-based organizations, and other community supporters, who act as spokespersons, ambassadors to deliver positive, affirming messages on the functions of our Territorial program.***

***At the present time, MCH management team's focus on the Program Priority Objectives set the stage for fostering greater collaboration amongst partners at all facets of the community, to include providers, civic organizations, the Faith community, neighborhood councils, and the media. Members of MCH Advisory Council, MCH Program Administrators, MCH's Data Committee, VI Department of Health's inter-departmental Directors, Practitioners (public and private), parents and consumer supporters will meet on a quarterly and/or biennial basis to guide and assess the implementation of the National and State Performance Measures and their link to the Healthy People 2010 Objectives. Moreover, access to local (VI) data sources, e.g., DOH Program Data, Hospital Discharge Data, and the MCH & CSHCN Title V Reporting System is currently more effective when obtained through direct contact with person(s) directly responsible. Therefore, working relationships are being strengthened in order to ascertain the processes and achieve support for the system of care desired.***

***The Maternal, Infant and Child Health Program management and staff holds responsibility for the execution of 6 Healthy People 2010 Objectives directly affecting women and children in the Territory, as follows: 16-6 To increase the proportion of pregnant women who receive early and adequate prenatal care; 16-7 To increase the proportion of pregnant women who attend a series of prepared childbirth classes (Developmental); 16-19a To increase the proportion of mothers who breastfeed their babies in early postpartum period; 16-20 To ensure appropriate newborn bloodspot screening; follow up testing and referral to services (Developmental); 16-22 To increase the proportion of children with special health care needs who have access to a medical home (Developmental); and, 16-23 To increase the proportion of Territories and States that have service systems for children***

***with special health care needs (Developmental).***
***Provision for the implementation of a Comprehensive Awareness Multi-media Campaign territory-wide is a work in progress, and it is another core developmental, infrastructure-building objective. The campaign is designed to involve and inform parents, students, community agencies, businesses, religious groups, and concerned citizens about MCH & CSHCN and its services, and it is anticipated to enhance the likelihood of successful outcomes for the program.***

***We will reach out to the community via diverse communication sources, i.e., website, print and electronic media to promote and highlight the need for increased engagement. Also, the community will be educated on issues such as the benefits of a 'medical home'; on the establishment of comprehensive adolescent healthcare; and the process of eliminating disparities in health and healthcare. Utilizing access to a myriad of consumer-friendly venues, MCH & CSHCN and its affiliates will disseminate program brochures and pamphlets strategically placed at community centers, schools, churches, movie theaters, beauty and barber salons, department stores and supermarkets, etc. Also, we will use every opportunity to participate in outdoor events frequented by residents and the Annual Public Health Week open house activities - another ideal civic engagement. Moreover, we will network with and educate children and parents/caregivers at MCH clinic sites, annual conferences, family fun days, and educational seminars and/or after-school and summer camps.***

***MCH & CSHCN management will enlist its students, parents, staff, directors, and community collaborators to share information with the attendees at these venues and events. In addition, we will produce a short video Power Point presentation highlighting the program and will market it to attract consumers and collaborators. Recruiting volunteers and attracting community resources is a desired outcome of the media campaign. This media campaign is intended to reach a broad cross section of Virgin Islands residents.***

***Continuous Quality Improvement (CQI) is impacted through stages of evaluation strategies that will direct the program vis-a-vis a tri-level approach of short-term, intermediate, and long-term outcomes. An essential Short-Term Outcome is an increased awareness of MCH & CSHCN and its programs and services. Core Program Priorities and its affiliated Healthy People 2010 Objectives seek to improve the awareness of and access to quality and expansive healthcare services to women, infants, children, adolescents (students), and other interested consumers.***

***Change in Knowledge and Attitude is a primary objective linked to the evaluation strategies that MCH &CSHCN will promote in order to generate an interest in and continuous support for an improved system of care accessible by the aforementioned populations. In order to track these actions, MCH & CSHCN management will engage program staff working in concert with health care providers, Council members, and community (parents and students) collaborators to administer and monitor various evaluation tools. For client / consumer-oriented evaluations, products such as Service Perception Questionnaires, Client Satisfaction Surveys, and a Suggestion Box for Client Input will all provide vital knowledge on how MCH & CSHCN service delivery is viewed. Then, the program's clinical and administrative functions will be measured through instruments such as the Client Chart Reviews, Site Visit Reviews, and the Practitioners / Providers Quality Assurance Checks. All collected data will be aggregated, analyzed, and reported to the respective sources mandated under Title V policies and procedures.***

***With an increased awareness, change in knowledge, and change in attitude, the next step is Intermediate Outcomes - Altered behavior. Change in behavior will be assessed and attested by improved access to and increased participation in clinic and community-based programs and services. Furthermore, there will be an evident buy-in for the***

***implementation of the 'medical home' concept, for formalized adolescent healthcare programs and services, and for a reduction in disparities in health and healthcare services. Finally, achieving Long-Term Outcomes throughout the program duration is a challenge and somewhat complex, as its dependent on sustainability and continuity in the commitment of collaborators. As mentioned earlier, this sometimes fluctuates; however, every effort will be made to implement our Program Priorities and the linked Healthy People 2010 Objectives in a more efficient and effective manner.***
***Adolescents of diverse racial, ethnic backgrounds and those of low socio-economic status remain under-served due to the inconsistency between pediatric and adult medical care services. While there is no specific NPM/SPM the program realizes the need to focus on increasing access to age-appropriate services for adolescents 10-20 years. HP2010 1-4b addresses this priority need with the goal to increase the proportion of persons who have a specific source of ongoing care (Children and youth aged 17 years and under). There is also a sub-population of adolescents who are not reached because they are not in school due to dropping out, being incarcerated or unemployed. The availability of age-appropriate services for these adolescents inclusive of components of a healthy youth development model is under discussion with the FQHC on St. Thomas. //2010//***

## C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 99 | 99 | 100 | 100 | 95 |
| Annual Indicator | 96.9 | 100.0 | 100.0 | 86.7 | 40.3 |
| Numerator | 1619 | 27 | 25 | 130 | 81 |
| Denominator | 1670 | 27 | 25 | 150 | 201 |
| Data Source | | | | | NBS Program |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 95 | 95 | 95 | 95 | 95 |

**Notes - 2008**
Denominators for 2005/2006 reflect initial positives for limited screening: TSH, PKU. MSUD, Homocystinuria, Hemoglobinopathies, Galactosemia, and G6PD.

Denominators for 2007/2008 reflect initial positives for expanded screening - total 48 disorders.

Numerators for 2005-2008 reflect rescreening, final diagnosis, counseling and enrollment in appropriate treatment for identified disorder.

All data obtained from the Newborn Screening Database.

**Notes - 2007**
Denominator reflects number of children initially screened positive for sickle cell disease, hypothyroidism and G6PD. While there were initial positives in other categories, e.g. biotinadase, galactosemia, cystic fibrosis and PKU, follow-up testing was normal and further medical management was not needed or recommended.

Numerator reflects number of children re-screened with confirmatory diagnosis made.

**a. Last Year's Accomplishments**
All babies born in community hospitals were screened for 48 inheritable disorders by PerkinElmer Genetic Screening Laboratory using mass spectrometry. Some of the disorders include but are not limited to: sickle cell hemoglobinopathies, galactosemia, hypothyroidism, G6PD, acylcarnitine and amino acid profiles, cystic fibrosis and biotionidase deficiency. Patients and families with positive results receive genetic counseling, case management and comprehensive care within 2 months of diagnosis.
94.5% of newborns (1743 of 1844) received genetic / metabolic screening in calendar year 2008, with four (4) children identified with sickle cell disease, and one (1) with congenital adrenal hyperplasia.
A Hematology Clinic meets monthly, and offers sub-specialty consultation with a board-certified pediatric hematologist. The clinic is integrated within the primary care pediatric clinics. This service is provided in both districts.
The laboratory reports G6PD deficiency, as confirmed by DNA, which has been beneficial in reducing both cost and time between the notification of results to MCH, and reduces the time to parental counseling. This type of reporting saves parents from having to go to the lab to have the test repeated before diagnosis and confirmation is given. It also helps to reduce the level of anxiety that parents experience in waiting for definitive results. 5.2% of newborns (n=90 of 1743) tested positive in CY 2008. The abnormal gene responsible for this inherited enzyme deficiency is located on the X-chromosome. Illnesses associated with G6PD deficiency occur more frequently in males than females, since males only have one X-chromosome. 87 or 61% of identified newborns were male. Though not a life threatening disorder, G6PD deficiency is an inherited condition in which the body doesn't have enough of the enzyme glucose-6-phosphate dehydrogenase, or G6PD, which helps red blood cells (RBCs) function normally. This deficiency can cause hemolytic anemia, usually after exposure to certain medications, foods, or even infections. Most people with G6PD deficiency don't have any symptoms, while others develop symptoms of anemia only after RBCs have been destroyed by hemolysis. In these cases, the symptoms disappear once the cause, or trigger, is removed. In rare cases, G6PD deficiency leads to chronic anemia. With the right precautions, a child with G6PD deficiency can lead a healthy and active life.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Achieve 99% initial screening of infants for selected genetic / metabolic disorders. | | | X | |
| 2. PerkinElmer Genetics to provide expanded screening. | X | X | X | |
| 3. Follow-up and track infants with unsatisfactory or abnormal results. | X | X | | |
| 4. Refer all children with a diagnosed metabolic/genetic disorder for appropriate follow-up and treatment. | X | X | | |
| 5. Refer all children identified with significant hemoglobinopathy for Pediatric Hematology evaluation and diagnosis by 4 months of age. | X | X | | |

| | | | | |
|---|---|---|---|---|
| 6. Board certified Pediatric Hematologist continues to provide service on a contractual basis. | X | X | | X |
| 7. Develop referral mechanism for off-island pediatric metabolic / genetic centers. | X | X | | |
| 8. Utilization of an integrated newborn genetic-metabolic and hearing screening database for tracking and surveillance | | | X | X |
| 9. Update and distribute newborn screening brochure to providers and parents. Provide parent educational material. | X | X | X | |
| 10. Continue to work towards development of data linkage of newborn screening records and birth certificates. | | | X | X |

**b. Current Activities**

A decrease in hospitalizations and complications in children diagnosed with sickle cell disease continues. Hospitalizations are reported by parents and accurate data is not available. However, prevention of morbidity and mortality due to early identification, treatment and management continues to be successful, and there were no deaths reported due to complications during this fiscal year. 100% of newborns confirmed with sickle cell disease receive an initial pediatric hematology evaluation by four (4) months of age and are entered into a comprehensive system of care.

To date for two (2) infants were diagnosed with sickle cell, or other hemoglobin variant disease. 100% are enrolled in comprehensive care and receive prophylactic penicillin. Newborns identified with sickle cell trait remains constant at 1 in 8 of those screened. Trait counseling is offered to parents and families of these newborns.

Their families receive on-going education and counseling on sickle cell disease management.

The program continues to strive to achieve 100% of screening territory-wide. For CY '07, 81% of newborns in the territory were screened. Program staff will continue follow-up efforts to ensure that all infants with abnormal lab results are followed until diagnosis, or are determined to be lost to follow-up.

Dr. Condon Richardson, a local pediatric hematologist based at the Charlotte Kimelman Cancer Center on St. Thomas conducts monthly hematology clinics on both islands.

**c. Plan for the Coming Year**

All babies born in the territory will continue to be screened. Those identified as positive will receive comprehensive diagnostic and confirmatory testing.

Follow-up testing is provided for all abnormal and/or unsatisfactory results to ensure the completion of screening.

Patients and families with positive results will receive access to genetic counseling, case management and comprehensive care. Sub-specialty consultation with a board-certified pediatric hematologist will continue to be available. Parent support group activities on each island will continue.

The integrated newborn metabolic/genetic/hearing tracking and surveillance database will provide useful information for statistical reporting and tracking.

The program anticipates that the 100% follow-up rate for entry into comprehensive medical care for children diagnosed with sickle cell disease or other metabolic disorders will be maintained.

Public health nurses will continue to follow-up this special needs population by providing case management and care coordination services.

Pending the availability of fiscal resources, TA for all program staff, partners and parents will be sought from SERGG or MCHB related to identification, management and treatment of metabolic or other disorders identified through expanded screening.

A program of specialized health care that addresses the specific needs of adolescents with sickle cell (coping skills, dating, sexual practices, the risks of pregnancy, transitioning to high school and then college with sickle cell disease) will be initiated. The program will provide educational material about these issues, implement talk sessions and establish a teenage support group and a counseling group for those adolescents with sickle cell. With the increased number of children on Hydrea, the importance of protection against pregnancy must be emphasized; therefore, a

collaborative effort will occur between MCH and Family Planning to give advice on safe sexual practices.
We will continue to revise and upgrade our health care protocol for all children with hemoglobinopathies to meet the current HIH standards.
Efforts have been initiated to transition newborn screening to the hospitals. DOH MCH & CSHCN Program will continue to provide access to follow-up, management and comprehensive care for all children identified through screening with an inheritable disorder. Both hospitals are in negotiations with New Jersey State Laboratory. It is anticipated that this transition will be completed by the end of December 2009.

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 30 | 30 | 50 | 30 | 30 |
| Annual Indicator | 24.9 | 49.0 | 22.5 | 20.0 | 12.2 |
| Numerator | 320 | 563 | 235 | 250 | 187 |
| Denominator | 1284 | 1149 | 1044 | 1248 | 1530 |
| Data Source | | | | | HealthPro/MCH |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 40 | 40 | 40 | 40 | 45 |

**Notes - 2008**
VI is participating in National CHSCN Survey this year. Data for this measure obtained from MCH nursing staff in St. Thomas-St. John District.

Denominator obtained from Health Pro database.

**Notes - 2007**
The numerator reported in 2007 is obtained from clinic data from St. Thomas only.

**Notes - 2006**
The numerator reported in 2006 is obtained from clinic data for St. Thomas only.

**a. Last Year's Accomplishments**
Program nurses, physicians and allied health staff continued to work with families to make decisions about care and services for children. Meetings and case conferences attended during this period focused on the transition from early intervention programs to school; children with special needs in the foster care system; and collaborations between public health nurses and families.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Families are represented on the MCH Advisory Council. Involve families in task forces, advisory and planning committees. | | X | | X |
| 2. Encourage family members participation in development of parent education materials and fact sheets. | | X | | X |
| 3. Parent advocacy organizations are program partners and provide training, resources and services. | | X | | X |
| 4. Continuation and strengthening of existing linkages and referral network. | | X | | X |
| 5. Encourage family representation at the annual AMCHP meeting. | | | | X |
| 6. Support opportunities for family members to attend local or national conferences, meetings and workshops. | | X | | |
| 7. Provide compensation for family participation in program activities, conferences, meetings. | | X | | |
| 8. Program staff assists families with identifying needed resources. | | X | | |
| 9. Develop and administer exit surveys to determine satisfaction after clinic visits. | | X | X | X |
| 10. Develop and administer annual family satisfaction surveys. | | X | X | X |

**b. Current Activities**

The program continues to focus most of the personnel time and other resources toward the provision of direct health care services to children and their families.

Family members participate on the V.I. Alliance for Primary Care, MCH Advisory Council, Needs Assessment Planning Group and the Medical Home Task Force. Bi-lingual family members are being recruited for participation on these committees.

LEADD trainees for the Spring 2009 semester completed course work on cultural competencies, advocating for families and effective means of incorporating families in the decision making process of programs and services offered by MCH and community groups. The information was conveyed through lectures, via role playing, and by interviewing families to determine whether or not MCH and various community organizations have been effective in meeting the needs of families with children with special health care needs. As part of their course work, they had to determine the means in which families will be incorporated in their projects and implement a plan of action to accomplish this.

The program did not meet the characteristics of family members of children with special health care needs as paid staff or consultants specifically for the purpose of family advocacy. However, there are several administrative staff members who are parents of special needs children who access sub-specialty services and function as advocates when necessary.

**c. Plan for the Coming Year**

The Virgin Islands Title V Program plans to address this measure through the continuation and strengthening of existing linkages and referral networks.

Other strategies to be employed are: expand outreach and support to culturally diverse populations, providers and community organizations; identify barriers that prevent families from accessing health care on a regular basis; encourage family-professional partnerships in all program activities, i.e., including families in all workgroups, advisory committees and provide adequate compensation for their time; as well as encourage and promote participation in parent mentor/support groups among families, family advocacy organizations and providers.

Activities to develop and implement an action plan to enhance services for families of children with special needs, including training for parents and families, will be achieved based on available financial resources.

Develop and administer annual family satisfaction surveys. These are complete in English and are awaiting translation to French Creole and Spanish. (This activity was deferred due to lack of fiscal and human resources. It remains a priority of the program).
Other actions to achieve this goal, are to continue coordination efforts with Child Find activities in Part C-IDEA Program, Department of Education-Special Education, Pre-School Education & Head Start Programs, and encourage participation through culturally sensitive and appropriate family training and education.
Training for staff, families and providers towards achievement of this goal will be provided in collaboration with a program partner, V.I. Family Information Network on Disabilities (VIFIND). This community based advocacy agency teaches parents about their rights under the Americans with Disabilities Act, IDEA and Section 504 of the Rehabilitation Act, and empowers them to actively participate in decisions affecting their child with special needs. Parents are assisted to locate information, resources, programs and services, and to communicate effectively with professionals and services providers.
Families will be asked to participate in the pilot survey for one part of the obesity project, and they will also be asked to participate by giving suggestions about methods to implement the WE CAN program that will be effective in meeting the needs of our population.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 20 | 20 | 55 | 50 | 50 |
| Annual Indicator | 24.9 | 50.6 | 43.5 | 38.1 | 54.6 |
| Numerator | 320 | 581 | 454 | 475 | 835 |
| Denominator | 1284 | 1149 | 1044 | 1248 | 1530 |
| Data Source | | | | | HealthPro/MCH |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 55 | 60 | 60 | 60 | 60 |

**Notes - 2008**
More than half of all CSHCN with high complexity diagnoses receive care coordination services at MCH clinics in both districts.
These services meet the American Academy of Pediatrics defines the medical home as “a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

Denominator obtained from HealthPro database.

**Notes - 2007**
The numerator reported in 2007 is obtained from clinic data from St. Thomas only.

**Notes - 2006**

The numerator reported in 2006 is obtained from clinic data from St. Thomas only.

**a. Last Year's Accomplishments**

The definition of "Medical Home" as it's applied on the US mainland has a different meaning in the Territory. The Title V program is considered the medical home, as defined by the American Academy of Pediatrics, for a large percent of the CSHCN population. For many families, the medical home is where a child with special health care needs and his or her family can access medical care coordination, usually by a public health nurse or service coordinator with the involvement of the pediatrician. These nurses and families work together and coordinate all of the medical and non-medical services needed to help CSHCN achieve their potential. Factors that continuously impact this are the increasing numbers of underinsured and uninsured families; welfare to work policies for single head of household families that offer low paying jobs with little or no medical insurance benefits or paid days off; and an overall poverty rate of 47.5.6% for children under 18 years in the Territory in single mother homes. In addition, private pediatricians and other primary care providers routinely refer families to the program for access to specialty care that is otherwise unavailable.

The 330 funded health centers remain without full-time pediatricians; this places severe limitations on their ability to provide medical homes.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Encourage families of CSHCN to access comprehensive care through a medical home. | | X | | X |
| 2. All primary and specialty care is coordinated by public health nurses in the Title V program. | X | X | | |
| 3. Continue to promote medical home through partnerships and collaboration with community-based organizations and other agencies that serve the special needs population. | | X | | X |
| 4. Educate families of children with special health care needs of the importance of medical home . | | X | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Families with private or group insurance may opt to remain with a private provider for primary care and access Title V services for specialty or sub-specialty care only.

The program authorizes medical, laboratory and diagnostic care, and other treatment services including rehabilitative services, for children who are uninsured or families that are determined unable to otherwise pay for services.

The program continues to provide medical homes for children with special health care needs. Public health nurses continue to provide care coordination. Interventions included advocacy, education, case management, counseling, and nursing procedures. Services were provided in a variety of locations including in the home, by phone and in other locations such as hospitals, clinics, schools or child care settings.

**c. Plan for the Coming Year**

Existing partnerships such as those with the non-profit 330 FQHC's, private pediatricians and the Part C-IDEA Program will be utilized to plan, develop and implement an on-going training program.
A plan to promote the medical home approach through collaborations with community based organizations and professionals, i.e., child care providers, will assure their assistance in encouraging families to access the comprehensive and coordination of services available to them in a medical home.
Reconvene the medical home task force to implement a plan to promote the medical home approach.
Parents are encouraged, within their financial confines, to establish a relationship with a private pediatrician.
Establish data collection mechanism to monitor, track and determine positive outcomes and the successful achievement of HP 2010 Objective 16.22 - Increase the proportion of children with special health care needs who have access to a medical home (Developmental).
Promote the use of Bright Futures, which is a tool and a best practice for increasing quality of health care and health education for children and families. This will assist the program in furthering the goals of the MCH Priorities.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 30 | 35 | 35 |
| Annual Indicator | 24.9 | 27.0 | 43.5 | 25.0 | 52.0 |
| Numerator | 320 | 310 | 454 | 312 | 795 |
| Denominator | 1284 | 1149 | 1044 | 1248 | 1530 |
| Data Source | | | | | HealthPro |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 35 | 35 | 40 | 40 | 50 |

**Notes - 2007**
Numerator obtained from MCH clinics in both districts reflects families reporting a source of insurance other than Medicaid.

**Notes - 2006**
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

**a. Last Year's Accomplishments**
This measure is not directly applicable to the territory. There is a Medicaid cap that places severe limitations on the ability to provide insurance for eligible families. SCHIP funds are utilized

to pay unpaid medical expenses for children with Medicaid.
There are no HMO's, MCO'S or PPO's providing Medicaid managed care coverage.
Some private sector employers provide medical benefits for their employees with no family coverage options.
The population known to be below the federal poverty level is presumed eligible for Medical Assistance. However, the poverty threshold for annual allowable income to qualify for Medicaid in the VI is $9,500 for a family of five compared to the national average of $23,497 (Census Bureau 2004) for a family of five. This requirement causes difficulty for uninsured families to qualify for Medical Assistance and creates barriers to accessing health care resources and services. These uninsured individuals are generally unable to afford health insurance premiums and are therefore not as likely to seek preventive or primary care. The actual cost of providing Medicaid services to this population who would otherwise meet eligibility criteria is unknown.
Government programs, clinics and hospitals (2) provide health care services at little or no cost; everyone, including low income, uninsured or underinsured individuals and families have access to essential services. Families of children with special needs who have insurance through MAP do not have the ability under program requirements to access care at private providers, thereby limiting their choices of providers. Children with special health care needs usually require a higher and more comprehensive level of health care beyond that required by normal children, and are more likely to experience catastrophic illnesses. These populations of children and families generally have extremely low incomes and are more likely to be uninsured. Children with health insurance are likely to obtain adequate health care, therefore insurance coverage, and the type and extent of coverage is an important indicator of access to care. Children who are under/uninsured usually have more emergency room visits and hospitalizations, and time lost from school. Adequate insurance allows access to comprehensive care, which in turn reduces emergency room visits, hospitalizations, and time lost from school or work.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. The Title V program provides access to specialty and sub-specialty services | X | X | | X |
| 2. All children in the territory have access to these services regardless of source of payment or ability to pay for services. | X | X | | X |
| 3. Refer all families without insurance to Medical Assistance program to determine eligibility. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
A sliding fee scale is available for clinic services. Income eligibility is based on 250% of the federal poverty income guidelines.
The Government of the Virgin Islands requires all of its employees to be covered by group medical insurance. The current carrier, CIGNA, is considered a PPO with most local providers a part of the network.
Families without health insurance are less likely to have a regular source of care and access the health care system only when necessary in order to avoid out-of-pocket costs.
The Title V program provides access to services, i.e., diagnostic, laboratory, specialty and sub-

specialty care, for families with no insurance coverage who are not eligible or do not meet certification standards for the Medical Assistance Program.

**c. Plan for the Coming Year**

The program will continue to provide sub-specialty clinics to children with special health care needs utilizing contracted pediatric sub-specialists. Sub-specialists from Puerto Rico conduct monthly clinics in pediatric neurology, orthopedics, hematology and cardiology. All children in the territory have access to these services regardless of source of payment or ability to pay for services. The availability of these services has reduced the high cost of off-island travel, enabled the clinics to be community-based, increased communication, reduced lost time from work for parents/caregivers, and enhanced the quality and continuity of care. Off-island referrals are primarily for diagnostic services such as cardiac catheterization, cardiac sonography, brainstem audio-evoked response testing, and less frequently, oncology, endocrinology, gastro-enterology and neuro-psychology services that are not available on-island for the pediatric population.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 30 | 30 | 50 | 30 | 30 |
| Annual Indicator | 24.9 | 50.0 | 19.4 | 14.8 | 0.0 |
| Numerator | 320 | 574 | 203 | 185 | 0 |
| Denominator | 1284 | 1149 | 1044 | 1248 | 1530 |
| Data Source | | | | | MCH Program |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 35 | 35 | 40 | 40 | 40 |

**Notes - 2008**

Information for this measure was not collected.

**Notes - 2007**

Numerator reflects # of referrals to community based services in both districts include after-school programs, family support and advocacy programs.

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Referrals to community based services in both districts include after-school programs, family support and advocacy programs.

**a. Last Year's Accomplishments**
Efforts to strengthen relationships with other community providers in the coordination of services, to reduce the duplication of services, to determine unmet needs, and to assure that the children requiring services receive them.
A system for tracking referrals was instituted by program nurses in the St. Thomas District.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Families are referred to appropriate community service agencies or organizations. | | X | | |
| 2. Maintain and periodically update as needed a resource directory of all community-based services and organizations. | | X | X | X |
| 3. Continue to assist families in accessing services based on identified needs. | | X | | |
| 4. Develop and implement a referral / feedback system for tracking purposes. | | X | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The program provided information and referral services to appropriate agencies based on families identified needs.

**c. Plan for the Coming Year**
Better case management efforts with individuals from MCH, Infants and Toddlers (Part C), Allied Heath Care Providers, MCH Social Worker, the Dept of Education, particularly Special Education and Division of Mental Health meeting on a regular basis to discuss the needs of those children with special health care needs and make sure that a comprehensive plan is in place in which the services that these children need are in place.
The CFVI (Community Foundation of the Virgin Islands) has published an updated directory of community organization that serve the Virgin Islands and a copy of this directory is in the MCH clinic and is being utilized to direct families to various service providers.
MCH staff has established communication with several of these organizations and has obtained brochures and information to distribute to the clients.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 30 | 30 | 35 |
| Annual Indicator | 24.9 | 20.5 | 2.6 | 1.2 | 0.7 |
| Numerator | 320 | 235 | 27 | 15 | 11 |
| Denominator | 1284 | 1149 | 1044 | 1248 | 1530 |
| Data Source | | | | | MCH Program |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 20 | 20 | 20 | 25 | 25 |

**Notes - 2008**
Numerator reflects data provided by MCH Nursing in St. Thomas-St. John District.

**Notes - 2007**
Numerator reflects the # of youth who transitioned to adult health care services in St. Thomas-St. John District.

**a. Last Year's Accomplishments**
The program utilized a plan for youth and adolescents with special health care needs transitioning to adulthood. The plan is based on the Healthy and Ready to Work model which facilitates the integration of service systems to address the health issues of this population. Public health nurses ensured appropriate referrals for all adolescent and young adult clients to the appropriate agencies for health/school/work transition.
The plan supports skill-building opportunities for youth and their families. It supports their involvement as decision makers in their health care, education and employment.
Improvement in transition activities related to increasing family/youth advocacy and connecting families/youth with information regarding community / university resources for educational and vocational planning.
Collaboration and coordination continued with several agencies to assure effective transition - Departments of Education, Vocational Education; Department of Human Services, Vocational Rehabilitation; Department of Labor, Job Training and Placement; Community Health and 330 Centers; community based organizations, i.e. V.I. Resource Center for the Disabled, University of the Virgin Islands Center for Excellence on Developmental Disabilities, Virgin Islands Assistive Technology Foundation, Inc., Family Voices, V.I. Center for Independent Living, and V.I. Family Information Network on Disabilities.
LEADD trainees received further instruction and technical assistance on the management of transitioning children with special health care needs from MCH to adult health care services.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Develop transition plan in collaboration with Vocational Education, Department of Education, adult health care services and other appropriate agencies. | | X | | X |
| 2. Facilitate interagency collaboration to share resources and | | X | | X |

| | | | | |
|---|---|---|---|---|
| skills. | | | | |
| 3. Provide transition information to families. | X | X | | |
| 4. Solicit and encourage family and adolescent participation in transition planning. | X | X | | |
| 5. Establish data collection mechanism to monitor and track successful and effective transition. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Transition planning with families is provided by public health nurses. Established transition planning checklists are utilized.

**c. Plan for the Coming Year**
Facilitate interagency collaboration to share resources and skills.
Use information received from the needs assessment to promote transition planning from pediatric to adult health care.
Continue to utilize, implement and evaluate transition planning health care plans for families of all children and adolescents with special health care needs. Continue collaborations with other agencies and community-based partners to address health care transition issues.
Encourage adolescents to participate in transition planning and provide age appropriate transition services.
Establish data collection mechanism to monitor and track successful and effective transition.
Use data to determine positive outcomes and achievement of HP 2010 Objective 16.23 - Increase the proportion of Territories and States that have service systems for children with special health care needs (Developmental).

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 90 | 90 | 70 | 70 |
| Annual Indicator | 0.0 | 45.7 | 63.0 | 80.0 | 31.2 |
| Numerator | 0 | 467 | 382 | 943 | 215 |
| Denominator | 5088 | 1023 | 606 | 1179 | 690 |
| Data Source | | | | | MCH Program |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 70 | 75 | 75 | 75 | 75 |

**Notes - 2008**
Data remains unavailable from VI Immunization Program. The National Immunization Survey is currently being conducted this fiscal year.

Denominator obtained from children in this age group receiving any service at MCH clinics in the St.Thomas-St. John District.

Numerator reflects number of children in this age group with complete immunizations at MCH clinic in the St. Thomas-St. John District.

**Notes - 2007**
Data reported for this measure was provided by the MCH clinic in the St. Croix district only which is collected manually. This does not reflect territorial data. Denominator is the total # of children in this age category who received any immunizations. Numerator is the number who meet the requirements of this measure.
The VI Immunization Program does not have a database system in place to provide territorial information for this measure

**Notes - 2006**
The VI Immunization Program remains unable to provide data for this measure. The denominator reflects children in this age category who access services at the MCH & CSHCN Program on both islands and received all immunizations during these visits.

**a. Last Year's Accomplishments**
Technical and contractual challenges and deficiencies with the Immunization Registry are not resolved according to Immunization Program staff. Data required for this performance measure remains unavailable from the Immunization Program.
MCH nurses and physicians ensure that infants and children receive age appropriate immunizations well child visits, primary and preventive care visits.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Assessment of immunization status included in each primary and preventive care visit. | X | | X | |
| 2. Continue WIC immunization linkage. | X | | X | |
| 3. Families are provided literature on AAP/CDC Guidelines on Immunizations. | X | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
The Women, Infants and Children Nutrition Program (WIC) ensured that children participating in the program completed their immunization schedule through age 2. Participants who are not up to date with their immunization are referred to the Immunization Clinic as per

Memorandum of Understanding that VI WIC has with the immunization program according to policy and procedure 2.09.
Immunizations continue to be a vital part of every primary and preventive care visit at MCH clinics, the community heath centers and other clinics.
MCH staff participated in training activities sponsored by the Immunization program.

**c. Plan for the Coming Year**

The Vaccine For Children Program's mandate related to uninsured or Medicaid eligible/certified children can qualify to receive vaccine through from the program will continue to be implemented.
The program will continue to strive for at least 95% of all children receiving services will have complete recommended immunizations by age 3 through continuous review of immunization status and parental education.
This is especially crucial since the VIDOH Immunization Registry does not have to capability to produce valid and / or reliable data for FY 2007 or 2008 reports. Immunization will continue to be a vital part of every primary and preventive care visit at MCH clinics, the community heath centers and other clinics.

MCH program will continue to assure access to vaccines that are required for child care and school entry, and maintain access to vaccines that are indicated in some high risk children.
Annual quality assurance reviews via random chart reviews to determine compliance with recommended immunization guidelines will be conducted quarterly. In addition to measuring compliance with vaccine schedules, the reviews will identify areas such as missed opportunities, barriers faced by parents when attempting to vaccinate their children and provide a mechanism to document recommendations to improve rates.
In order for MCH & CSHCN clinical staff to keep up with ever changing immunization policies, promote attendance at training sessions and annual immunization conference.
Continue efforts to raise immunization rates through promotion of awareness by means of outreach activities, distribution of parent education, identification of children who are not up to date.
Continue WIC linkage.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 20 | 20 | 15 | 15 | 15 |
| Annual Indicator | 23.4 | 22.0 | 16.4 | 16.4 | 5.2 |
| Numerator | 71 | 67 | 60 | 60 | 19 |
| Denominator | 3039 | 3039 | 3667 | 3667 | 3667 |
| Data Source | | | | | Vital Records |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |

| Is the Data Provisional or Final? | | | | Final | Provisional |
|---|---|---|---|---|---|
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 15 | 15 | 15 | 15 | 15 |

**a. Last Year's Accomplishments**

Provided information to adolescents on age appropriate topics such as delay in sexual activity; sexual coercion; abstinence; refusal skills; and protection against STDs and HIV/AIDS. Sessions were held at public schools, juvenile centers, faith based organizations, and summer camps. A total of 1,273 teens attended in 94 sessions.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide and promote referrals to the Family Planning Program's adolescent health outreach services. | X | | | |
| 2. Provide access to comprehensive services, STD counseling and testing for adolescents. | X | X | | |
| 3. Continue to engage adolescents through outreach activities that emphasize responsible decision making | X | X | | |
| 4. Group sessions and other activities to promote wellness among the teen population. | X | X | X | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The Family Planning Program continued efforts to decrease teen births by providing confidential counseling and contraceptive services. FP Program staff continues to support teen pregnancy prevention activities by engaging adolescents through outreach activities that emphasize responsible decision making; education related to STD prevention and provision of clinical services. Staff continues to provide education and outreach for clients aged 15-17 on reproductive health topics such as abstinence, decision making skills, healthy relationships, male responsibility, parent-child communication, safer sex, sexual responsibility, teen pregnancy issues and sexually-transmitted infections.

**c. Plan for the Coming Year**

The Family Planning Program will continue to strive to increase awareness, especially to adolescents, on choices and consequences as they relate to sexual involvement. Outreach staff will continue to provide sessions specifically for teens.

Encourage adolescent male involvement in family planning outreach activities, emphasizing shared responsibility and STD/HIV prevention..

The Family Planning Program will continue to provide access to comprehensive services, STD counseling and testing, with special counseling for adolescents.

Outreach and community education efforts will continue to provide information through print, radio and TV media.

Group sessions and other activities are being planned to promote wellness among the teen population.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 30 | 30 | 35 | 35 | 20 |
| Annual Indicator | 0.0 | 0.0 | 1.4 | 1.1 | 8.5 |
| Numerator | 0 | 0 | 126 | 87 | 606 |
| Denominator | 9144 | 9016 | 9016 | 7866 | 7130 |
| Data Source | | | | | Dental Program |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 10 | 15 | 15 | 15 | 20 |

**Notes - 2008**
Data for this denominator obtained from the 2006 VI Community Survey by the Eastern Caribbean Center - University of the Virgin Islands.

Numerator obtained from the DOH Division of Dental Services for the St. Thomas-St. John District.

**Notes - 2006**
Numerator reflects number of children in this age category who received sealants through the DOH Division of Dental Health.

**a. Last Year's Accomplishments**
Dental services were available through the dental clinics administered by the Department of Health. Services include: examinations, fluoride applications, fillings and extractions. Sealants are not offered due to lack of funding. The Medical Assistance Program (MAP) does not cover this service for enrolled children. The Title V Program provided financial assistance for CSHCN requiring surgical or periodontal treatment that were not covered by the Medical Assistance Program. It is not anticipated that the Medicaid Program will have the resources to cover this service for VI children. Dental clinics will continue to provide other oral health services, including assessment, oral examination, fluoride applications, restorative fillings and extractions.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Promote use of protective sealants. | | | X | |
| 2. Screening and assessments for other dental conditions, | | | X | |

| | | | | |
|---|---|---|---|---|
| preventive dental care and referral as appropriate. | | | | |
| 3. Collaborate with WIC Program and Division of Dental Health Services to promote early start of good oral health practices. | | X | X | |
| 4. Develop and implement a data collection mechanism to assure the targeted population is receiving oral health services. | X | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

The Title V Program provided financial assistance for CSHCN requiring surgical or periodontal treatments who were not covered by the Medical Assistance Program or were uninsured. It is not anticipated that the Medicaid Program will have the resources to cover this service for VI children. Dental clinics continue to provide other oral health services, including assessment, oral examination, fluoride applications, restorative fillings and extractions.

In the St. Thomas-St. John District a total of 2,251 children received dental services. The School Based Preventive Program provided screening and fluoride applications for 1544 students in the St. Thomas/St. John School District -- grades K, 5th and 9th. 606 children received protective sealants. DOH MIS-HealthPro database reports a total 532 children in the 6-9 years age group with Medicaid received services in both districts. The Medical Assistance program does not collect or report this data.

**c. Plan for the Coming Year**

The water supply in the Virgin Islands is not fluoridated. The use of sealants and fluoride has been proven to reduce or eliminate decay in the permanent teeth of children. Though this measure relates to a population based preventive service, providing sealants will impact on direct care service dollars. Funding is allocated from the Title V Block Grant to assist with purchase of sealants and other supplies needed for these services.

Partnership established with the pediatric dentist to assist the program in providing the spectrum of oral health services, especially to the CSHCN population, will be continued. This partnership is anticipated to address community needs related to oral health and provide education to students, families, child care providers and other professionals related to maintaining healthy teeth, prevention of tooth decay and proper nutrition. In addition, they will provide increased and improved access to dental services and expand sources of protective sealants.

Promote prevention activities related to oral health education targeting the general public in collaboration with the Division of Dental Services.

Training for physicians and other health care providers in oral health screening as part of routine health care will be undertaken.

Develop and implement a data collection mechanism to assure the targeted population is receiving oral health services.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 3 | 3 | 3 | 2 | 2 |
| Annual Indicator | 0.0 | 0.0 | 0.0 | 11.6 | 4.4 |
| Numerator | 0 | 0 | 0 | 3 | 1 |
| Denominator | 27564 | 25996 | 25996 | 25805 | 22697 |
| Data Source | | | | | OHS |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 2 | 1 | 1 | 1 | 1 |

**Notes - 2007**
Data provided by the Office for Highway Safety, VI Department of Public Safety. Numerator reflects territorial data.

**a. Last Year's Accomplishments**
This data is not available from the Office of Vital Records and Statistics, and there is no Child Death Fatality Review Committee in the VI. The VI Office for Highway Safety reported 1 fatality in this age group as a result of injuries caused by motor vehicle collision. However, this is not substantiated by data from DOH Bureau of Health Statistics which reports no deaths occurred.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue to partner with VI-EMS and Office of Highway Safety (VIOHS) to promote injury prevention and traffic safety activities in the community. | | X | | X |
| 2. Continue to raise awareness on the importance of seat belt use and child passenger restraint seats. | | X | X | |
| 3. Increase public awareness activities to include alcohol and other substance abuse safety issues as related to motor vehicle use. | | X | X | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
There are no official reported deaths in this age group due to motor vehicle crashes.
The Emergency Medical Services staff provided training on injury prevention, infant and child safety, traffic safety including bike, skating, and motor vehicle passenger safety education to students, school staff, community organizations and other providers throughout the year. In addition, first responder and basic cardio-pulmonary resuscitation training were offered.
A pubic awareness and information campaign utilizing public service announcements and print media related to injury prevention is on-going. The Division of Emergency Medical Services is

located organizationally within the Department of Health.
In addition, the Office of Highway Safety (VIOHS) has on on-going media campaign regarding substance use (alcohol and other drugs) and driving. VIOHS strategies to reduce crashes, injuries and deaths include activities in reducing alcohol related deaths, increasing safety seat belt usage, proper use of child restraint seats, and reducing pedestrian deaths.

**c. Plan for the Coming Year**
The program will continue to partner with VI-EMS and Office of Highway Safety (VIOHS) to promote injury prevention and traffic safety activities in the community.
Continue to raise awareness on the importance of seat belt use and child passenger restraint seats through presentations, outreach fairs and child safety seat clinics. School-based health center providers will be included in this partnership.
Increase public awareness activities to include alcohol and other substance abuse safety issues as related to motor vehicle use.
VIOHS will partner with the National Guard Counter Drug Program to include instruction in the elementary and high school curriculum on the effects, dangers and consequences of driving under the influence of alcohol.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 50 | 50 | 45 |
| Annual Indicator | | 49.5 | 45.5 | 43.8 | 30.3 |
| Numerator | | 830 | 800 | 775 | 558 |
| Denominator | | 1676 | 1760 | 1771 | 1844 |
| Data Source | | | | | WIC/PedNSS |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 45 | 50 | 50 | 50 | 50 |

**a. Last Year's Accomplishments**
The Virgin Islands WIC Program continues all efforts to actively promote, support and protect breastfeeding within the territory. VI WIC continues to remain the 'beacon of light' for breastfeeding promotion within the territory, as the only organization, that consistently promotes and supports breastfeeding within the VI.
Provided breastfeeding information to all prenatal clients at certification, as well as individualized assistance to breastfeeding moms with problems.
Nutrition Education and WIC program materials translated in Spanish are available to serve the Spanish speaking population.
Breastfeeding rates continue to be high in the Virgin Islands with a territorial rate of 88.1% at discharge and 61.1% at 6 months. The exclusive breastfeeding rate is 5.7%. Trends in the breastfeeding rate in the Virgin Islands have shown a steady increase from 67% in 1988 to 88% in 2008.

WIC continues to utilize the Maryland WIC computer system, WIC on the WEB (WOW). This is a state-of-the-art, up to date and virtually paperless system that is in compliance with all WIC federal guidelines.
WIC is now a part of the Pediatric Nutrition Surveillance System (PedNSS).

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The VI WIC Program promotes breastfeeding through community and public awareness education activities using television, radio and print media. | | | X | X |
| 2. Provide literature on breastfeeding to prenatal and postpartum clients. | | X | | |
| 3. Provide lactation counselors (WIC Program)at both hospitals. | X | X | X | |
| 4. All WIC waiting room areas are breastfeeding friendly. | X | X | X | |
| 5. Discharge surveys to breastfeeding mothers provide a mechanism to monitor breastfeeding rates. | | X | | X |
| 6. Continue to coordinate breastfeeding activities with the WIC Program for pregnant women, mothers and infants. | X | X | X | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
To ensure that the WIC Program continues to promote, support and protect breastfeeding among WIC participants.
Continue efforts to assure mothers that breast milk alone is sustainable to babies for up to six months. WIC will also continue to provide support for breastfeeding mothers who work.
The exclusive breastfeeding rate continues to remain around 5.7%. Moms are continually encouraged to breastfeed and are very comfortable breastfeeding in WIC clinic settings.
Breastfeeding Counselors continue to provide professional intervention to WIC in the following ways: consultations to WIC clinic staff; outpatient help to breastfeeding clients; and in hospital assistance to breastfeeding moms.

**c. Plan for the Coming Year**
Increase breastfeeding among new mothers by providing direct support and counseling in both WIC and MCH Clinics.
Continue coordination activities with the WIC Program to achieve HP 2010 Objective 16-19a - Increase the proportion of mothers who breastfeed their babies in early postpartum period.
Maintain a breastfeeding environment within the WIC Program so that breastfeeding continues to be chosen as the preferred method of infant feeding by WIC mothers.
To develop, procure or revise nutrition education materials that are VENA friendly, which would enhance nutrition information given to clients at their nutrition education sessions.
Provide WIC clients with adequate nutrition education to make informed, lifestyle change decisions, using effective nutrition education interventions.
Provide breastfeeding information and aides to breastfeeding moms so that they may have a successful breastfeeding experience.
Provide counseling, support and assistance to WIC moms with breastfeeding problems.
To procure breast pumps and other breastfeeding aides for use in WIC clinics.

The Title V program will continue to coordinate breastfeeding activities with the WIC Program for pregnant women, mothers and infants. This includes referrals for care from WIC to the MCH program and from MCH to WIC. Public health nurses will use opportunities to promote and support breastfeeding.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 95 | 95 | 96 | 96 | 90 |
| Annual Indicator | 86.7 | 95.3 | 85.3 | 79.3 | 92.7 |
| Numerator | 1449 | 1607 | 1501 | 1405 | 1709 |
| Denominator | 1672 | 1686 | 1760 | 1771 | 1844 |
| Data Source | | | | | NBS Program |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 90 | 95 | 95 | 95 | 95 |

**a. Last Year's Accomplishments**

The integrated newborn screening database was modified and updated to provide reports. The database currently provides data on birth admission, follow-up outpatient screening and audiological diagnostic reports. However, challenges remain with generating integrated reports necessary for the follow-up and tracking of infants referred for additional screening or audiological evaluation.

93% (1709 of 1844) of newborns were screened this fiscal year. 1 infant out of 126 referred for additional screening, audiological evaluation and diagnosis was identified with hearing loss and referred to the Early Intervention Program.

Increased communication between the Nursery and MCH -- results of hearing screens being placed on the newborn discharge summary and on the It's a boy/ It's a girl card has been effective in catching newborns that initially failed a hearing screen and need to be re-tested earlier during their 2 week postnatal visit rather than later when they demonstrate language problems. Those that still fail on repeat testing are immediately referred to ENT for full evaluation.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide otoacoustic emissions screening for all newborns before hospital discharge or by one month of age. | | | X | |
| 2. Provide hearing screening technicians on a daily basis. | | | X | |
| 3. Provide literature on newborn hearing screening for prenatal providers. | | X | | |

| | | | | |
|---|---|---|---|---|
| 4. Provide parent education literature on hearing screening. | | X | | |
| 5. Develop and distribute a family resource guide for children identified with hearing loss. (See discussion under SPM #5). | X | X | | |
| 6. Increase awareness about the benefits of newborn hearing screening and early identification of hearing loss. | | X | X | |
| 7. Maintain integrated database into one system for data collection, tracking, reports and analysis. | | | | X |
| 8. Evaluate qualitative screening data to determine program efficiency in screening, identification of hearing loss and referral to early intervention services. | | | | X |
| 9. Ensure enrollment into early intervention services for newborns diagnosed with a hearing loss by 3 months of age. | X | X | | |
| 10. | | | | |

**b. Current Activities**

The program is funded 100% by the Title V Program. The Newborn Hearing Screening Program will continue utilizing portable otoacoustic emissions equipment to test newborns at the two hospitals on St. Thomas and St. Croix. Newborns who need follow-up screening will be referred to the Infants and Toddlers (Early Intervention) Program. Brainstem audio-evoked response tests are conducted by the MCH and CSHCN Program audiologist on St. Croix.
Updated OAE testing equipment was received on both islands. This increased the ability for more precise and accurate testing results.

**c. Plan for the Coming Year**

Newborn Hearing Screening will continue at both hospitals.
Newborn Hearing Screening Technicians will provide assistance with follow-up for infants who need rescreening or referrals for audiological assessments.
Audiologists will provide follow-up for infants at-risk for late onset hearing loss.
Families of newborns identified with hearing loss will be contacted by program staff to ensure follow-up and enrollment into early intervention by 6 months of age.
Develop and implement referral and reporting mechanism to ensure enrollment into early intervention for each newborn diagnosed with a hearing loss. Challenges still exist with gathering timely follow up data on infants referred for further diagnostic evaluation. MCH Program will continue to improve data quality, collection, tracking and reporting procedures by evaluating ways to improve the existing database system.
Newborn hearing screening/follow-up rates will continue to be monitored on a monthly basis.
Strategies will be developed to address screening barriers, such as obsolete screening equipment. Pending availability of financial resources, updated screening equipment will be purchased for both districts.
Increase awareness about the benefits of newborn hearing screening and early identification of hearing loss.
Plan and implement activities to assure achievement of HP 2010 Objective 28-11 - Increase the proportion of newborns who are screened for hearing loss by age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services by age 6 months (Developmental).

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 15 | 15 | 15 | 15 | 10 |
| Annual Indicator | 0.0 | 19.0 | 22.4 | 8.8 | 12.0 |
| Numerator | 0 | 6603 | 7785 | 2283 | 2728 |
| Denominator | 36058 | 34817 | 34817 | 25805 | 22697 |
| Data Source | | | | | VICS/ HealthPro |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 10 | 10 | 10 | 10 | 10 |

**Notes - 2008**
Denominator obtained from 2006 VICommunity survey.
Numerator reflects number of children accessing services at MCH clinics in both districts.
The Medical Assistance Program is not required to collect or report this data to CMS.

**Notes - 2007**
Data is not available from the Medical Assistance Program. Estimates are based on number of children without insurance who receive services at MCH clinics.

**a. Last Year's Accomplishments**
Children with Special Health Care Needs are disproportionately low-income, and because of this, they are at a greater risk of being uninsured. Moreover, their needs for health care are greater. MCH and CSHCN Programs refer families to MAP for eligibility determination. There is no formal outreach program for the MAP or SCHIP Programs, since there are such limited resources to offer the families.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Refer all families without health insurance to the Medical Assistance Program to determine eligibility. | X | X | | X |
| 2. Document and provide data for children (number and percent) without health insurance enrolled and receiving services. | | | | X |
| 3. Continue to provide care coordination services to children with special health care needs who access services. | X | X | | |
| 4. All children registered in the Title V program receive services regardless of insurance availability or ability to pay. | X | X | | |
| 5. Uninsured and underinsured children will continue to be provided financial assistance for access to diagnostic, specialty and sub-specialty care. | X | X | | |
| 6. | | | | |
| 7. | | | | |

| | | | | |
|---|---|---|---|---|
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Families determined to be eligible for the Medical Assistance Program, based on the federal income guidelines for poverty, are referred to the MAP Program. The actual number of eligible families with children is unknown as the MAP data system does not provide this information.
One of the LEADD trainees is setting up a project to look at the various types of insurance coverage for individuals with mental illnesses to determine if these individuals receive lower coverage for mental illness versus physical illness. If this is the case, the data collected will serve as grounds for advocating for new legislation. This project addresses both the child and adult population.

**c. Plan for the Coming Year**
All children registered in the Title V Program receive services regardless of insurance availability or ability to pay.
Uninsured children will continue to be provided financial assistance for access to diagnostic, specialty and sub-specialty care based on need and availability of resources.
Families without health insurance will continue to be referred to the Medical Assistance Program to determine eligibility.
Continue to provide care coordination services to children with special health care needs who access services.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 10 | 10 | 10 |
| Annual Indicator | | 12.6 | | 4.4 | 11.8 |
| Numerator | | 277 | | 186 | 276 |
| Denominator | | 2198 | | 4261 | 2339 |
| Data Source | | | | | WIC/PedNSS |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 10 | 10 | 10 | 10 | 10 |

**Notes - 2007**
Data not available from the WIC at the time of this report.

**Notes - 2006**
Data not available from WIC Program.

**a. Last Year's Accomplishments**

Increase breastfeeding among new mothers by providing direct support and counseling in both WIC and MCH Clinics.
Continue coordination activities with the WIC Program to achieve HP 2010 Objective 16-19a - Increase the proportion of mothers who breastfeed their babies in early postpartum period.
Maintain a breastfeeding environment within the WIC Program so that breastfeeding continues to be chosen as the preferred method of infant feeding by WIC mothers.
To develop, procure or revise nutrition education materials that are VENA friendly which would enhance nutrition information given to clients at their nutrition education sessions.
Provide WIC clients with adequate nutrition education to make informed, lifestyle change decisions, using effective nutrition education interventions.
Provide breastfeeding information and aides to breastfeeding moms so that they may have a successful breastfeeding experience.
Provide counseling, support and assistance to WIC moms with breastfeeding problems.
To procure breast pumps and other breastfeeding aides for use in WIC clinics.
The Title V Program will continue to coordinate breastfeeding activities with the WIC Program for pregnant women, mothers and infants. This includes referrals for care from WIC to the MCH program and from MCH to WIC. Public health nurses will use opportunities to promote and support breastfeeding.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue to provide participants (parents) education on basic nutrition and importance of physical activity. | X | X | X | |
| 2. Continue to implement an intervention strategy that provides nutrition education to at-risk participants (parents). | X | X | | |
| 3. Continue current year activities. | X | X | X | X |
| 4. Implement a plan to address pediatric obesity prevention and management. | | X | X | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Clinic staff will continue to provide nutrition education activities for WIC participants to assist them in preparing healthy meals for their families and to also keep them in good health.
WIC participants receive nutrition education according to risk and program policies and procedures that would enable them to make informed decisions about their nutritional health.
***/2010/ Women with Focus operates territorially as a non-profit organization whose focus is on informing and educating the community on proper nutrition and providing outlets for the inclusion of physical activity for children, adolescents and adults. //2010//***

**c. Plan for the Coming Year**
Ensure that WIC clients are certified and receive nutrition services according to established guidelines.
Continue revision of policies and procedures so that they are compatible with WIC on the Web (WOW) functions and VENA.
Continue to train staff and implement changes necessary for the Value Enhanced Nutrition

Assessment (VENA) requirements in order to continue to provide optimal nutrition services for WIC clients.
WIC Program staff will continue to provide participants education on basic nutrition and the importance of physical activity.
Continues to provide specialized food packages based on individual needs.
Provide food preparation classes for participants.
Implement a plan to address pediatric obesity prevention and management.
WIC participants will continue to receive nutrition assessment, counseling and education at certification. Nutrition education is provided individually and in interactive group sessions.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 1 | 1 | 1 |
| Annual Indicator | 1.3 | 1.5 | 1.8 | 1.8 | 0.4 |
| Numerator | 22 | 25 | 32 | 32 | 8 |
| Denominator | 1672 | 1686 | 1751 | 1771 | 1844 |
| Data Source | | | | | Vital Records |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 1 | 1 | 1 | 1 | 1 |

**a. Last Year's Accomplishments**
Data reported from Vital Statistics for CY 2007 shows that 1.8% (32 of 1771) of pregnant women reported smoking in the last three months of pregnancy.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Encourage cessation of tobacco, alcohol and other drug use during pregnancy. | X | X | | |
| 2. Continue to provide risk screening and encourage first trimester enrollment into prenatal care. | X | X | X | |
| 3. Provide care coordination for women at risk for poor birth outcomes through outreach activities to ensure access to prenatal care. | X | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |

| | | | | |
|---|---|---|---|---|
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Prenatal care providers in the MCH and Community Health Clinics promote tobacco cessation. Prenatal clinic staff provide education on risk behaviors during pregnancy to all prenatal women. This includes the impact of tobacco on fetal brain development and the increased risk of preterm birth and poor birth outcomes.

Cessation guides and literature are provided. Referrals are made to the Tobacco Prevention and Cessation Program.

**c. Plan for the Coming Year**

Tobacco and other drug use during pregnancy is proven to cause poor pregnancy outcomes - infant mortality, prematurity and very low birth weight. Tobacco cessation will lead to prevention of long term health complications and second hand smoke exposure to infants and children.

Encourage cessation of tobacco, alcohol and other drug use during pregnancy.

Provide clients with education, informational materials and referrals to encourage and assist with smoking cessation.

Continue to provide risk screening and encourage first trimester enrollment into prenatal care.

In collaboration with VIPI, provide care coordination for women at risk for poor birth outcomes through outreach activities to ensure access to prenatal care.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 5 | 5 | 2 | 2 | 2 |
| Annual Indicator | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Numerator | 0 | 0 | 0 | 0 | 0 |
| Denominator | 8821 | 8821 | 8821 | 8751 | 8534 |
| Data Source | | | | | Vital Records |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 2 | 1 | 1 | 1 | 1 |

**a. Last Year's Accomplishments**

The rates for youth suicide in the VI are unknown. Official data is not available from DOH Vital Records and Statistics. There are no other known sources of data for this measure.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Address the need for community awareness and education on youth suicide prevention. | | X | X | |
| 2. Develop and implement a referral plan to improve opportunities for children and adolescents to receive assessment, evaluation and treatment. | X | X | | X |
| 3. Collaborate with appropriate agencies to educate the public and professionals about depression and youth suicide. | | X | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Lutheran Social Services has established a hot-line (TEEN-LINE). This line provides confidential, free phone counseling and encourages teens to be aware of suicide symptoms in others they know or in themselves.

DOH Children's Mental Health Services provide screening and treatment on a limited basis due to a lack of providers. According to data reported for FY 2008, this Division provided services to 134 children ages 0 -- 20. These services included individual, family and group therapy; monitoring of medication and psychiatric evaluations. The Division continues to provide comprehensive community-based mental health to children, adolescents and adults in the Frederiksted catchment area.

The Child & Family Therapist provided much needed services to the substance abuse and child and adolescent populations.

**c. Plan for the Coming Year**

Though suicide is the 11th leading cause of death in the US, it is not proven to be among the leading causes of death in adolescents, or a priority area of concern in the VI. Valid, accurate data is not available to document suicide attempts or completion. Increasing awareness through health education and promotional activities on mental health, suicide prevention and identification of at-risk children needs to be a collaborative effort with public and private agencies.

While there are services in the community available to children and youth who experience any of these issues, the information may not be readily available to them at the time of need.

Coordinated efforts need to be undertaken to address the need for community awareness and education on youth suicide prevention. A plan to improve opportunities for children and adolescents to receive assessment, evaluation and treatment must be developed and implemented.

Collaborate with appropriate agencies to educate the public and professionals about depression and youth suicide through educational conferences, radio, newspaper and television programs.

Assure information and referral sources for families of children requiring mental health assessment, management and treatment are disseminated to schools, community & faith-based organizations and programs or agencies where adolescents congregate, e.g. after school youth activities.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |
| Annual Indicator | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Numerator | 0 | 0 | 0 | 0 | 0 |
| Denominator | 1672 | 1676 | 1513 | 1771 | 1844 |
| Data Source | | | | | Vital Records |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | Yes | Yes | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |

**Notes - 2007**
This measure does not apply to VI. There is a Level II Neonatal ICU. There are no facilities for high-risk deliveries and neonates.

**Notes - 2006**
This measure does not apply to VI. There is a Level II Neonatal ICU. There are no facilities for high-risk deliveries and neonates.

**a. Last Year's Accomplishments**
There are no Level III facilities in the Virgin Islands. This NPM is not applicable.
A Level II nursery exists on St. Thomas and St. Croix, which are both staffed with neonatologists. Newborns requiring neurosurgery or cardiac surgery may be transferred to Puerto Rico or Florida. Coordination and communication among health care and related systems were maximized to increase service utilization, and minimize gaps and duplication. The infrastructure for provision of services was strengthened in order to make a meaningful impact on the health status of women.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. There are no Level III facilities in the Virgin Islands. | | | | |
| 2. Prenatal clinic staff will perform appropriate risk assessment and encourage women to seek care for signs of early labor. | X | X | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
There are no plans to open a Level III nursery in the Virgin Islands. Present arrangements will be continued.
Prenatal clinic staff will perform appropriate risk assessment and encourage women to seek care for signs of early labor.

**c. Plan for the Coming Year**
There are no plans to open a Level III nursery in the Virgin Islands. Present arrangements for maternal transport will be continued on a case by case basis.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | 65 | 65 | 65 | 65 | 65 |
| Annual Indicator | 63.3 | 64.2 | 66.2 | 62.6 | 23.1 |
| Numerator | 1059 | 1083 | 1167 | 1109 | 426 |
| Denominator | 1672 | 1686 | 1763 | 1771 | 1844 |
| Data Source | | | | | Vital Records |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 70 | 70 | 70 | 75 | 75 |

**Notes - 2008**
The data for calendar year 2008 from the Office of Vital Records and Statsitics is incomplete, and only reflects 33% of the records for birth certificates which have been evaluated and edited as of reporting date.

Final data for this numerator is anticipated to be available by the end of October 2009.

**Notes - 2007**
Numerator reflects data available for the first three quarters of CY 2007.

Denominator reflects number of live births admissions.

**a. Last Year's Accomplishments**
The MCH Unit provides primary and preventive care to pregnant women, mothers and infants. Data estimates for the MCH-St. Croix and St. Thomas East End Medical Clinic prenatal clinics show that 38.5% of prenatal patients (276 of 716) enrolled in prenatal care in the first trimester in CY 2008. In comparison, preliminary data for the same period from the Bureau of Health Statistics show that 23.1% % of women (426 of 1844) accessed care in the first trimester. This

data is incomplete.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue partnerships with programs that encourage early enrollment in early prenatal care. | X | | X | X |
| 2. Increase healthy birth outcomes through promotion of healthy behaviors and lifestyles. | X | X | | |
| 3. Plan and implement activities to meet HP 2010 Objective 16.6 - Increase the proportion of pregnant women who receive early and adequate prenatal care (80%). | X | X | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Outreach activities are on-going to high or at-risk pregnant women in low-income, underserved communities by VI Perinatal, Inc. (VIPI) outreach staff and case managers who encourage women to seek early and continuous care to guarantee the best possible outcome for delivery. An on-going awareness and social marketing campaign by VIPI also stresses the importance of early and adequate prenatal care in preventing preterm births and poor birth outcomes.

**c. Plan for the Coming Year**

Continue partnerships with programs that encourage early enrollment in early prenatal care, i.e. Family Planning, VIPI, Ryan White Title IV, through outreach, education and awareness activities. Prenatal clinic staff will perform appropriate risk assessment and encourage women to seek care for signs of early labor.
Increase healthy birth outcomes through promotion of healthy behaviors and lifestyles.
Plan and implement activities to meet HP 2010 Objective 16.6 - Increase the proportion of pregnant women who receive early and adequate prenatal care (80%).

## D. State Performance Measures

**State Performance Measure 1:** *The percent of CSHCN clients who access family support services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 50 | 50 | 55 |
| Annual Indicator | | 50.0 | 43.5 | 30.0 | 6.5 |
| Numerator | | 574 | 454 | 375 | 100 |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | | 1149 | 1044 | 1248 | 1530 |
| Data Source | | | | | MCH Program |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 55 | 55 | 60 | 60 | 55 |

**Notes - 2008**
Data reflects information from St. Thomas/ St. John district only.

**Notes - 2007**
Numerator reflects # of families using services such as VI FIND (Family Information Network on Disabilities).

**a. Last Year's Accomplishments**
Case management and care coordination services, family counseling, and respite care are a few of the services needed by families of children with special health care needs. While these may be available from several sources, families may have challenges accessing them. Efforts to identify appropriate support and referral services for families with CSHCN, and to provide up to date information for families relative to available community resources.
A directory of community-based services and outreach programs was compiled for use by families and providers. This was done in response to a need for a source of updated information in one document.
Efforts to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and to assure that the children requiring services receive them continued. A system for tracking referrals was instituted by Program nurses in the St. Thomas District.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue efforts to identify appropriate support and referral services for families with CSHCN | | X | | X |
| 2. Provide current information for families relative to available community resources. | X | X | | |
| 3. Provide families with linkages to community organizations and parent advocacy groups | X | X | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Provide families with linkages to community organizations and parent advocacy groups. The Program provided information and referral services to appropriate agencies based on the families identified needs.

**c. Plan for the Coming Year**

Continue to identify information and support the needs of families through a referral network of community and faith based organizations and programs.
Continue to partner with parent groups, public and private agencies and service providers to build resources and increase capacity to meet family needs.
The Program has existing collaborative partnerships with community based organizations that provide services to children and families. These include, but are not limited to, advocacy groups, legal services, resource and training centers, child care providers, family support and faith based organizations.
The V.I. Alliance for Primary Care and the MCH Advisory Council, which includes members from these organizations are the focal points for developing and maintaining these community collaboratives to promote partnerships between families and service providers.
Continue to assist families in accessing services based on identified needs.
Utilize a referral / feedback system for tracking purposes, and to determine outcomes of services provided.
Continue efforts to implement family-centered, culturally competent, and community-based systems of referral and care, and to simplify access to these systems for families.
Periodically evaluate referral system to assure that it is consistent with the Title V vision to integrate and strengthen community-based programs into a system of services that is more accessible and responsive to families and communities.
Establish data collection mechanism to monitor, track and determine positive outcomes and successful achievement of HP 2010 Objective16-23 (Developmental) Increase the proportion of Territories and States that have service systems for children with special health care needs.

**State Performance Measure 2:** *Increase the percent of CSHCN families' participation in transition planning to at least 50%.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 25 | 35 | 40 |
| Annual Indicator | | 20.5 | 2.6 | 1.2 | 8.9 |
| Numerator | | 235 | 27 | 15 | 136 |
| Denominator | | 1149 | 1044 | 1248 | 1530 |
| Data Source | | | | | MCH Program |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 45 | 50 | 50 | 50 | 50 |

**Notes - 2008**
Data reflects information from the St. Thomas/ St. John district only.

**a. Last Year's Accomplishments**
Many children and adolescents with special health care needs are unable to maintain placement in higher education, sustain employment, or live independently and are less likely than their non-disabled peers to complete high school, attend college or to be employed. Their health care is generally managed by parents or guardians and they may have little experience managing their own health care, or understanding their medical conditions. Families may be unaware of the programs and resources that can assist. Pediatric and adult health care providers often do not communicate or collaborate to successfully transfer care from one to another.
The program utilized a plan for youth and adolescents with special health care needs transitioning to adulthood. The plan is based on the Healthy and Ready to Work model which facilitates the integration of service systems to address the health issues of this population. Public health nurses ensured appropriate referrals for all adolescent and young adult clients to the appropriate agencies for health/school/work transition. 9 young adults were successfully transitioned this

fiscal year.
The plan supports skill-building opportunities for youth and their families. It supports their involvement as decision makers in their health care, education and employment.
Improvement in transition activities related to increasing family/youth advocacy and connecting families/youth with information regarding community / university resources for educational and vocational planning is needed to achieve the goal of 50%.
Collaboration and coordination continued with several agencies to assure effective transition - Departments of Education, Vocational Education; Department of Human Services, Vocational Rehabilitation; Department of Labor, Job Training and Placement; Community Health and 330 Centers; community based organizations, i.e. V.I. Resource Center for the Disabled, University of the Virgin Islands Center for Excellence on Developmental Disabilities, Virgin Islands Assistive Technology Foundation, Inc., V.I. Center for Independent Living, and V.I. Family Information Network on Disabilities.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Encourage adolescents and their families to participate in transition planning. | X | X | | |
| 2. Utilize a transition checklist tool based on the Healthy and Ready to Work model. | | X | | |
| 3. Continue to work on the transition tool and work with youth to address medical transition issues. | X | X | | |
| 4. Assure comprehensive and timely transition to adult health care and employment. | X | | X | X |
| 5. Continue collaboration with appropriate agencies to ensure transition to adulthood and independence. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
Encourage adolescents and their families to participate in transition planning.

**c. Plan for the Coming Year**
Ensure that adolescents with special health care needs have a transition plan as part of care coordination.
Implement a plan to assure healthy and effective transition to adulthood including employment, healthcare and independent living activities.
Develop and implement a transition manual.
Continue to utilize the transition checklist based on the Healthy and Ready to Work model.
Actively seek involvement of youth in transition related training activities, i.e., workshops.
Continue collaborations with appropriate agencies to ensure transition to adulthood and independence.
Educate adult health care providers on the needs of transitioning youth and their families.

**State Performance Measure 3:** *The percent of CSHCN who receive coordinated, comprehensive care in a medical home.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 55 | 55 | 55 |
| Annual Indicator | | 50.6 | 10.8 | 38.1 | 54.6 |
| Numerator | | 581 | 113 | 475 | 835 |
| Denominator | | 1149 | 1044 | 1248 | 1530 |
| Data Source | | | | | MCH Program |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 60 | 65 | 65 | 65 | 65 |

**Notes - 2008**
Data for this measure was obtained from the VI DOH HealthPro database.

**a. Last Year's Accomplishments**
According to the American Academy of Pediatrics, the medical home is "a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care."
As of July 2008, the new National Center for Medical Home Implementation gives full support to the implementation of medical home among all who care for children even children with special health care needs. It has always been our policy to be a medical home to those children with special health care needs since there are no other health care providers that provide the services that MCH does.
For many VI families, the medical home is where a child with special health care needs and his/her family can count on having medical care coordinated, by a public health nurse or service coodinator with involvement of the pediatrician. These nurses and families work together and access all of the medical and non-medical services needed to help CSHCN achieve their potential. Factors that contribute to this are increasing numbers of underinsured and uninsured families; welfare to work policies for single head of household families that offer low paying jobs with little or no medical insurance benefits or paid days off; and an overall poverty rate of 46.7% for children under 18 years in the territory. In addition, private pediatricians and other primary care providers routinely refer families to the program for access to specialty care not otherwise available.
The program continues efforts to assure a medical home for all children with special health needs.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue efforts to assure a medical home for all children with special health needs. | | X | | X |
| 2. Provide access to comprehensive, coordinated medical health care services for CSHCN. | | X | | X |
| 3. Continue to incorporate and promote the medical home concept in planning efforts and program services. | | | | X |
| 4. Continue to provide education to parents on the importance of the medical home. | X | X | | |
| 5. | | | | |

| | | | | |
|---|---|---|---|---|
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Provide access to comprehensive, coordinated medical health care services for CSHCN.
Continue to work with primary care, allied health and other providers on ensuring continuity of care.
Public health nurses continue to provide leadership in case management and coordination of specialty clinics.
Home visits, or visits in the natural environment to provide services needed for CSHCN, are provided by nurses and allied health staff.
We are in the process of reviewing and revising our policies on the care and management of this special population so that we can truly implement the principles that are outlined above. We hope through better community collaboration and better case management that these principles will be implemented in our daily care of all our patients.

**c. Plan for the Coming Year**

Continue to incorporate and promote the medical home concept in planning efforts of the Program and services.
Increase the number of children and youth receiving comprehensive care through a medical home.
Continue to provide education to parents on the importance of having a medical home.
Provide additional staff training and development needed for the provision of care coordination including: medical home, transition of CSHCN, cultural competence, and community-based care.

**State Performance Measure 4:** *The percent of teen mothers who received parenting skills training.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 35 | 30 | 30 |
| Annual Indicator | | 33.5 | 22.4 | 36.2 | 52.6 |
| Numerator | | 68 | 41 | 55 | 120 |
| Denominator | | 203 | 183 | 152 | 228 |
| Data Source | | | | | Community based organizations |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 35 | 35 | 35 | 40 | 40 |

**Notes - 2008**

This information is based on the 2007 teenage birth rate vital records . The denominator is the actual number of births for the population aged 15-19 for 2007. 2008 data is incomplete. Numerator is based on information provided by community-based organizations that provide parenting classes.

**Notes - 2007**

Numerator obtained from agencies providing parenting skills training such as Family Resource Center, Lutheran Social Services and Childworth.
Denominator reflects preliminary data obtained from DOH - Bureau of Health Statistics.

**Notes - 2006**
This Denominator reflects estimated number of teen births ages 15-19 years obtained from the Bureau of Health Statistics.
Numerator reflects the number of teen receiving parenting skills education in the St. Croix District only.

**a. Last Year's Accomplishments**
Teen parenting classes are offered by various non-profit organizations throughout the Territory. Organizations such as the Village and Beyond Vision, seek to empower the youth through the improvement of both social and practical skills. For calendar year 2008, of the participants in the Beyond Vision program, 72% had an income level of below $10,000.00. 61% of participants were reported as being Hispanic and the remaining 39% were black. All participants received some form of government assistance, TANF- 50%, Food Stamps- 39%, Section 8 Housing- 100%. The Village offered their parenting services to 88 people in 2008 through their Project Strength program. Of that total, 17.05% were 14 years old and younger, 36.36% were 15-17 years old and 46.59% were 18 years old and older. 25% of the participants were of Hispanic descent and 75% were of African -- American/ Afro Caribbean descent. 52.27% were Male and 47.73% were Female.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Establish partnerships with health educators, guidance counselors or individuals from other community-based organizations who provide family support services. | | X | | X |
| 2. Develop and implement a referral system with CBO's that provide parenting skills / education programs. | | X | | |
| 3. Obtain and review criteria for evidence-based family support and parenting education programs. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
In addition to various non-profit organizations, the Department of Human Services continued collaboration with the Virgin Islands Housing Authority to provide direct service parent effectiveness sessions to young adults and older mothers and fathers.

**c. Plan for the Coming Year**
School based health service providers will be encouraged to offer parenting skills training. This should be accomplished through partnerships with health educators, guidance counselors or individuals from other community-based organizations who provide family support services.

Obtain and review criteria for evidence-based family support and parenting education programs.

**State Performance Measure 5:** *Percent of infants identified with hearing loss who are receiving appropriate intervention services by age 6 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 60 | 60 | 70 |
| Annual Indicator | | | | | |
| Numerator | | 3 | 3 | 2 | 1 |
| Denominator | | 22 | 70 | 217 | 126 |
| Data Source | | | | | NHS Program |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 80 | 90 | 95 | 95 | 98 |

**Notes - 2008**
The data for the denominator is obtained from infants who did not pass initial hearing screening in the birth admission and were referred to the Audiologist for follow-up testing.
The numerator indicates the number identified with permanent hearing loss and referred to early intervention services.

**Notes - 2006**
Data for denominator obtained from infants identified during hospital with possible hearing and referred for audiological diagnostic evaluation. Numerator indicates number identified with hearing loss and referred to Early Intervention Services

**a. Last Year's Accomplishments**
Healthy People 2010 Revised Objective 28-11: Increase the proportion of newborns who are screened for hearing loss by age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services by age 6 months, was used as the benchmark for continued implementation of hearing screening.
Appropriate and timely early intervention services before six months of age promote optimal language, cognitive, and social development
Newborn screening technicians are available on a daily basis including weekends and holidays.
Updated and high technology OAE equipment was purchased for both islands. Screening rates before hospital discharge increased to 93% from 79% in 2007.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Audiologists will perform diagnostic evaluation by 3 months of age to confirm permanent hearing loss (PHL). | X | | X | |
| 2. Refer infants identified with permanent hearing loss for early intervention services before six months of age | X | X | X | |
| 3. Continue to assist families in obtaining audiological evaluations. | X | X | | |
| 4. Provide literature on permanent hearing loss to parents and providers. | X | X | | |
| 5. Continue to monitor and track infants identified with PHL. | X | | | |

| | | | | |
|---|---|---|---|---|
| 6. Obtain technical assistance and training to improve data collection, analysis and reporting skills. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Training and evaluation for the screening technicians is on-going. On-site evaluations are done quarterly by the Territorial Audiologist to assess screening proficiency, communication / interaction with families; compliance with confidentiality rules and equipment care.

Continue to monitor and track infants identified with permanent hearing loss or impairment or have documented risk conditions for late onset of hearing loss.

Increased communication between the Nursery and MCH -- results of hearing screen being placed on the newborn discharge summary and on the It's a boy/ It's a girl card has been effective in catching newborns who initially did not pass the hearing screen and were able to be re-tested earlier during their 2 week postnatal visit, rather than later when they demonstrate language problems. Those that did not pass on repeat testing are immediately referred to the Audiologist for further testing and to ENT for full evaluation.

The Program continues to provide brochures explaining newborn hearing screening and explaining what to expect when a baby does not pass the hospital screening.

**c. Plan for the Coming Year**

Audiologists will perform diagnostic evaluation by 3 months of age to confirm permanent hearing loss (PHL).

Continue to assist families in scheduling audiological evaluations.

Continue to provide literature on permanent hearing loss to parents and providers.

Refer infants identified with permanent hearing loss for early intervention services before six months of age, to ensure appropriate and timely services to promote optimal language, cognitive, and social development.

Continue to monitor and track infants identified with PHL- amplification, and early intervention enrollment.

Obtain technical assistance and training to improve staff data collection, analysis and reporting skills.

Plan and implement activities to ensure achievement of HP 2010 Objective 28-11 - Increase the proportion of newborns who are screened for hearing loss by age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services by age 6 months.

The MCH & CSHCN Program will continue to refer infants with permanent hearing loss for EI services, and will monitor and track diagnostic audiological evaluations, confirmed hearing status, amplification, and EI enrollment status.

**State Performance Measure 6:** *Increase the rate of pregnant women who enroll in prenatal care in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 600 | 600 | 650 |

| | | | | | |
|---|---|---|---|---|---|
| Annual Indicator | | 642.3 | 661.9 | 626.2 | 231.0 |
| Numerator | | 1083 | 1167 | 1109 | 426 |
| Denominator | | 1686 | 1763 | 1771 | 1844 |
| Data Source | | | | | Vital Statistics |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 650 | 700 | 700 | 700 | 750 |

**Notes - 2008**
The data for calendar year 2008 from the Office of Vital Records and Statsitics is incomplete, and only reflects 33% of the records for birth certificates which have been evaluated and edited.

Final data for this numerator is anticipated to be available by the end of October 2009.

**a. Last Year's Accomplishments**
The Healthy People 2010 Revised Objective 16-16: Increase the proportion of pregnant women who receive early and adequate perinatal care beginning in the first trimester of pregnancy, was used as the benchmark for the promotion of early enrollment in prenatal care. The target rate of 600 per 1000 women was the goal set for this year. Based on data from the DOH Vital Records & Statistics in CY 2007, 62.6% of women were enrolled in the first trimester.
Prenatal care includes three major components: risk assessment, treatment for medical conditions or risk reduction, and education. The American College of Obstetricians and Gynecologists (ACOG) recommends that women receive at least 13 prenatal visits during a full-term pregnancy.
Prenatal care is more likely to be effective and produce better outcomes if care begins early in pregnancy and continues as recommended throughout the pregnancy.
The MCH Unit provides primary and preventive care to pregnant women, mothers and infants. Women have access to comprehensive reproductive health care, and a referral mechanism to the Family Planning Program.
A major focus of the V.I. Perinatal Inc., is to enroll women in prenatal care early.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue to provide access to prenatal care and encourage women to enroll early. | X | X | | |
| 2. Continue partnerships with programs that encourage early enrollment in prenatal care | | | | X |
| 3. Increase healthy birth outcomes through promotion of healthy behaviors and lifestyles | X | X | | |
| 4. Pregnant women will receive appropriate number of prenatal care visits that begins in the first trimester. | X | | | |
| 5. The Family Planning program will continue to provide pregnancy testing with early referral of women to prenatal care. | X | | X | |
| 6. Promote activities that reflect HP 2010 Revised Objective 16-16: Increase the proportion of pregnant women who receive early and adequate perinatal care beginning in the first trimester of pregnancy | | X | X | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Prenatal care is more likely to be effective if women begin receiving care early in pregnancy. Continue to provide access to prenatal care and encourage women to enroll early. Women beginning care in the third trimester and those receiving no prenatal care are at increased risk for poor pregnancy / birth outcomes.

The MCH Program continues to provide care coordination, health education and counseling to pregnant women with health and social risk factors associated with low birth weight and very low birth weight infants, in efforts to improve prenatal and birth outcomes.

Referrals are made to the WIC Program to supplement diets of pregnant women, who may be nutritionally at risk based on medical and nutritional assessment and federal poverty guidelines.

**c. Plan for the Coming Year**

Continue partnerships with programs that encourage early enrollment in early prenatal care, i.e. Family Planning, VIPI, Ryan White Title IV through outreach, education and awareness activities.

Prenatal clinics will perform appropriate risk assessment and encourage women to seek care for signs of early labor.

Increase healthy birth outcomes through the promotion of healthy behaviors and lifestyles.

Pregnant women will receive appropriate prenatal care that begins in the first trimester.

The Title V MCH/CSHCN Program Director will continue to serve on the VIPI Board of Directors and participate in activities to reestablish Fetal Infant Mortality Review Committee. The collaborative efforts of community partners will continue to sustain the VIPI's initiatives to address health disparities, access to quality care and improvement in the overall health of the community.

Continue to provide outreach in populations where perinatal illness and disability rates and mortality rates are highest, and who are most likely to have low incomes.

The Family Planning Program will continue to provide pregnancy testing with early referral of women to prenatal care.

Promote postpartum follow-up and family planning to decrease unplanned pregnancies, enroll women in care and encourage pregnant women to enroll early prenatal care.

**State Performance Measure 7:** *The rate per 10000 of hospitalizations due to asthma in children 0-14.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 5 | 5 | 5 |
| Annual Indicator | | 5.7 | 5.0 | 2.0 | 2.9 |
| Numerator | | 158 | 130 | 52 | 66 |
| Denominator | | 27671 | 25996 | 25805 | 22697 |
| Data Source | | | | | RLS & JFL Hospitals |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2009** | **2010** | **2011** | **2012** | **2013** |
| Annual Performance Objective | 5 | 5 | 5 | 5 | 5 |

**Notes - 2008**

Data from both island hospitals reflects in-patient admissions only. Average length of stay was 1.5 days.

**Notes - 2007**
Numerator reflects in-patient admissions to hospitals in both districts. Due to availability of pulse oximetry and stabilizing nebulizer/aerosol treatments in both MCH clinics, the number of children seen in emergency departments has dropped significantly.

**Notes - 2006**
Data for numerator obtained from Gov. Juan F. Luis Hospital on St. Croix. Represents number of hospital admissions with average stay of 2-5 days.

**a. Last Year's Accomplishments**
With the use of nebulizer treatments, the administration of the first dose of steroids in the clinic, and with careful follow-up, the number of ER visits and hospitalizations have decreased in this population. With continued parental and child education, and the use of preventative medications, the number of asthma exacerbations per year has also decreased.
Asthma education and prevention efforts were held in collaboration with organizations such as the American Lung Association (ALA), VI Chapter, the University of the Virgin Islands Cooperative Extension Program.
Provide asthma education resources to families, children and school personnel.
Encourage utilization of asthma plans obtained from ALA , National Institutes of Health and New York State DOH by Program staff.
The MCH Program utilizes the New York State Asthma action plan for parents and clinical management materials for the nurses and pediatricians to use in their education of parents.
School Health activities by the VI Chapter of the ALA and DOH Office of Minority Health included: in-school care and management, and health education (child self-care education, asthma management education) using the American Lung Association's Open Airways for Schools curriculum, and partnership promotion for asthma friendly school environments using the federal Environmental Protection Agency's Tools for Schools. Populations served included elementary and junior high schools and school staff.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Provide asthma education resources to families, children and school personnel | | X | | X |
| 2. Provide on-going and continuous asthma education and management to families with a focus on self-management. | X | X | | |
| 3. Continue to promote use of asthma plans to families. | X | X | | |
| 4. Design, establish and implement an asthma surveillance system to obtain accurate data collection for analysis to monitor quality of care and outcomes. | | | | X |
| 5. Promote activities to achieve HP2010 Objective 24 – Promote respiratory health through better prevention, detection, treatment and education | | X | | X |
| 6. Provide awareness and education programs for child care providers and early childhood school personnel. | | | | X |
| 7. Provide guidance in childhood asthma management and care via the provision of asthma resources to community health care providers, schools, day care facilities, children and families. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

Reductions in frequent hospitalization or emergency department admissions are an indicator of the health care system's success in helping families and children manage and control asthma.
In addition to the above, education on the proper use of MDI's and nebulizer treatments has been effective in children being treated appropriately. The use of handouts on asthma and asthma care has also been effective in improving parental awareness and appropriate treatment.
Implement existing asthma education plan to provide on-going and continuous asthma education and management to families with a focus on self-management.
Monitor outcomes of asthma education and management.
Provide asthma materials and resources on environmental triggers to primary care providers, schools and other interested individuals.
Collaboration with the American Lung Association (ALA), VI Chapter should be strengthened and new partnerships developed. This would provide opportunities for public health, schools and community organizations to work together to develop and implement an asthma plan including an evaluation and surveillance system.

**c. Plan for the Coming Year**

Promote activities to achieve HP2010 Objective 24 -- Promote respiratory health through better prevention, detection, treatment and education efforts.
Revision of the asthma care protocol.
Establishing an asthma clinic in which intensive instruction and health care management will occur.
Re-designing a health care plan for both parents and the school for each patient with asthma in accordance for the standards of the NIH -- NHLBI.
Education of school nurses about asthma and the updated guidelines for management and treatment.
Institution of peak flow meters in the clinics and at home for parents to be able to implement the appropriate treatment.
Provide awareness and education programs for child care providers and early childhood school personnel.
Design, establish and implement an asthma surveillance system to obtain accurate data collection for analysis to monitor quality of care and outcomes.
Promote awareness and prevention of asthma issues in young children through the promotion of Bright Futures guidelines as the standard for well-child care, and the promotion of medical homes for all children.
Utilize trained child care health consultants who are also public health nurses in the Title V Program, and are knowledgeable about asthma recognition and treatment; to train and assist child care providers to recognize, cope with, and prevent asthma, and to work with parents to reduce environmental triggers in the home and external environments to the extent possible.
Promote childhood asthma education and prevention activities for children and their families, and provide resources to assist families with asthma management skills to reduce hospitalizations.
Reductions in re-hospitalization are an indicator of the health care system's success in helping families and children manage and control asthma. Through a number of DOH programs, we provide guidance in childhood asthma management and care via the provision of asthma resources to community health care providers, schools, day care facilities, children and families.

## E. Health Status Indicators

**Introduction**

The challenges faced by the program in acquiring variable population-based data to address the respective health status indicators continued throughout this program year. MCH Director held discussions with the Office of Vital of Statistics to assess the level of resources required to fulfill

the delivery of quality and quantitative data. Feedback given indicates a willingness to comply; however, the output of data provided is inadequate for accurate, immediate use by the program. Dialogue will continue with the responsible parties and the department's Deputy Commissioner to assist in resolving this impediment to the surveillance, monitoring and evaluation process.
The data system of the Medical Assistance Program (MAP) does not have the functionality to provide the data needed to meet this indicators. An integrated data system is not in place. The program remains without access or linkage to the Medical Assistance database or reports. Addressing these issues in the MCH population and developing strategies to improve services is dependent on an aggressive data driven system with qualified data management support.

**Health Status Indicators 01A:** *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 11.4 | 10.7 | 10.2 | 11.6 | 3.4 |
| Numerator | 191 | 181 | 180 | 205 | 63 |
| Denominator | 1672 | 1686 | 1763 | 1771 | 1844 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**
Data obtained from DOH Vital Statistics. Information provided for numerator is provisional based on completion of compilation of certificates of live birth.

**Narrative:**
***/2010/ Final data for CY 2007 indicates that 11.6% (205 of 1771) weighed less than 2500 grams. Though this may be directly correlated to the 39.9% of women in this time period receiving adequate prenatal care, this is not known as DOH doesn't have the capability or data capacity to assess this occurrence. //2010//***

**Health Status Indicators 01B:** *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 10.5 | 9.4 | 9.4 | 10.6 | 2.4 |
| Numerator | 171 | 155 | 163 | 187 | 45 |
| Denominator | 1623 | 1642 | 1740 | 1771 | 1844 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**

Data obtained from DOH Vital Statistics. Information provided for numerator is provisional based on completion of compilation of certificates of live birth.

**Narrative:**
***/2010/ Final data for CY 2007 shows that 10.6% of births in this category were less than 2500 grams. This compares to 9.4% in 2006. //2010//***

**Health Status Indicators 02A:** *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 1.9 | 2.0 | 1.6 | 1.4 | 0.4 |
| Numerator | 32 | 33 | 29 | 24 | 8 |
| Denominator | 1672 | 1686 | 1763 | 1771 | 1844 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**
Data obtained from DOH Vital Statistics. Information provided for numerator is provisional based on completion of compilation of certificates of live birth.

**Narrative:**
***/2010/ There have been several challenges in accessing delivery and birth admission records for the period originally intended (2000- 2007). PMMRC is now auditing records on St. Croix for CY 2004. Final data from DOH Vital Records and Statistics shows that 1.4% (24 of 1771) births in CY 2007 were less than 1500 grams. CY 2008 data is not complete. //2010//***

**Health Status Indicators 02B:** *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 1.8 | 1.6 | 1.6 | 1.3 | 0.3 |
| Numerator | 29 | 27 | 28 | 23 | 5 |
| Denominator | 1623 | 1642 | 1740 | 1771 | 1844 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**

Data obtained from DOH Vital Statistics. Information provided for numerator is provisional based on completion of compilation of certificates of live birth.

**Narrative:**
***/2010/ Data obtained for the VI Office for Highway Safety shows 1 death (4.4 /100,000) occurred in children 14 years or younger due to motor vehicle crashes while 5 deaths (35.5/100,000) occurred in ages 15-24. //2010//***

**Health Status Indicators 03A:** *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 7.7 | 0.0 | 0.0 | 0.0 |
| Numerator | 0 | 2 | 0 | 0 | 0 |
| Denominator | 27564 | 25996 | 24669 | 25805 | 22697 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | Yes | Yes | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**
Denominator obtained from USVI Community Survey 2006, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from VI DOH Vital Statistics.

**Notes - 2007**
Denominator obtained from 2005 VI Household Survey, UVI Eastern Caribbean Center;
Numerator obtained from DOH Bureau of Health Statistics.

**Notes - 2006**
Data reported by VI Office of Highway Safety - Traffic Safety Facts. 2006

**Narrative:**
***/2010/ Based on the information received from the Office of Highway Safety and EMS there were no deaths this year in this population due to untintenional injuries. //2010//***

**Health Status Indicators 03B:** *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 7.7 | 0.0 | 11.6 | 4.4 |
| Numerator | 0 | 2 | 0 | 3 | 1 |
| Denominator | 27564 | 25996 | 24669 | 25805 | 22697 |

| | | | | | |
|---|---|---|---|---|---|
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | Yes | Yes | Yes |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**
Denominator obtained from USVI Community Survey 2006, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from VI Office of Highway Safety.

**Notes - 2007**
Denominator obtained from 2005 Household Survey, UVI Eastern Caribbean Center.
Numerator obtained from VI-Office for Highway Safety, Traffic Safety Facts, 2007.

**Notes - 2006**
Data reported by VI Office of Highway Safety - Traffic Safety Facts

**Narrative:**
***/2010/ Data obtained for the VI Office for Highway Safety shows 1 death (4.4 /100,000) occurred in children 14 years or younger due to motor vehicle crashes while 5 deaths (35.5/100,000) occurred in ages 15-24. //2010//***

**Health Status Indicators 03C:** *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 7.0 | 0.0 | 13.7 | 35.5 |
| Numerator | 0 | 1 | 0 | 2 | 5 |
| Denominator | 14086 | 14296 | 14296 | 14617 | 14085 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | Yes | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**
Denominator obtained from USVI Community Survey 2006, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from VI Office of Highway Safety.

**Notes - 2007**
Data obtained from VI-Office for Highway Safety, Traffic Safety Facts 2007.

Denominator obtained from 2005 VI Household Survey, UVI Eastern Caribbean Center.

**Notes - 2006**
Data provided by VI Office of Highway Safety- Traffic Safety Facts reports no deaths in this category.

**Narrative:**
***/2010/ Data obtained for the VI Office for Highway Safety shows 1 death (4.4 /100,000) occurred in children 14 years or younger due to motor vehicle crashes while 5 deaths (35.5/100,000) occurred in ages 15-24. //2010//***

**Health Status Indicators 04A:** *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 0.0 | 338.5 | 472.8 | 312.8 |
| Numerator | 0 | 0 | 88 | 122 | 71 |
| Denominator | 27564 | 25996 | 25996 | 25805 | 22697 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**
Denominator obtained from 2006 VICS, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from DOH EMS. Numbers represent St.Thomas-St. John District only.

**Notes - 2007**
Numerator obtained from VI-EMS and Office for Highway Safety, 2007 Pediatric Ambulance Calls / Traffic Safety Facts.

**Narrative:**
***/2010/ EMS pediatric ambulance call data for the St. Thomas-St. John District shows that 19 incidents of non-fatal injuries occurred during FY 2008. This data is not reported by age. Due to the on-going challenges of access to reliable data source for these indicators, it is not possible to have accurate comparisons in these rates from year to year. //2010//***

**Health Status Indicators 04B:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Indicator | 36.3 | 19.2 | 338.5 | 441.8 | 61.7 |
| Numerator | 10 | 5 | 88 | 114 | 14 |
| Denominator | 27564 | 25996 | 25996 | 25805 | 22697 |
| Check this box if you cannot report the | | | Yes | | |

| | | | | | |
|---|---|---|---|---|---|
| numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**
Denominator obtained from 2006 VICS, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from DOH EMS. Numbers represent St.Thomas-St. John District only.

**Notes - 2007**
Numerator obtained from VI-EMS and Office for Highway Safety, 2007 Pediatric Ambulance Calls / Traffic Safety Facts.

**Notes - 2006**
Data obtained from VI Office of Highway Safety - Traffic Safety Facts

**Narrative:**
***/2010/ EMS pediatric ambulance call data for the St. Thomas-St. John District shows that 19 incidents of non-fatal injuries occurred during FY 2008. This data is not reported by age. Due to the on-going challenges of access to reliable data source for these indicators, it is not possible to have accurate comparisons in these rates from year to year. //2010//***

**Health Status Indicators 04C:** *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| **Annual Objective and Performance Data** | **2004** | **2005** | **2006** | **2007** | **2008** |
|---|---|---|---|---|---|
| Annual Indicator | 0.0 | 0.0 | 1,070.2 | 1,135.7 | 71.0 |
| Numerator | 0 | 0 | 153 | 166 | 10 |
| Denominator | 14086 | 14296 | 14296 | 14617 | 14084 |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Provisional |

**Notes - 2008**
Denominator obtained from 2006 VICS, Eastern Caribbean Center, University of the Virgin Islands.

Numerator obtained from DOH EMS. Numbers represent St.Thomas-St. John District only.

**Notes - 2007**
Numerator obtained from Office for Highway Safety, 2007 Traffic Safety Facts.

**Notes - 2006**

Data provided by VI Office of Highway Safety- Traffic Safety Facts

**Narrative:**
***/2010/ EMS pediatric ambulance call data for the St. Thomas-St. John District shows that 19 incidents of non-fatal injuries occurred during FY 2008. This data is not reported by age. Due to the on-going challenges of access to reliable data source for these indicators, it is not possible to have accurate comparisons in these rates from year to year. //2010//***

**Health Status Indicators 05A:** *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Indicator | 34.2 | 24.1 | 26.6 | 28.4 | 39.5 |
| Numerator | 125 | 115 | 127 | 148 | 182 |
| Denominator | 3657 | 4779 | 4779 | 5210 | 4606 |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2008**
Data provided by VI Family Planning Program FY 2008.

Data provided from DOH STD/HIV/AIDS/TB Prevention Program for FY 2008. Inclusive of all testing sites in the territory.

**Notes - 2006**
Data provided from DOH STD/HIV/AIDS/TB Prevention Program for FY 2006.

**Narrative:**
***/2010/ VIFPP has done the majority of Chlamydia/GC testing ( of 3,321 tests done, 1,295 were done at VIFPP clinics sites). The USVI STD Program does the contact tracing of partners of positive clients from all testing sites. All sites provide basic infertility services at Level I and include an initial interview, education, physical examination, counseling, and appropriate referral. In CY 2008 22% (182 of 825) of females 15-19 years tested positive. This is a decrease from 28.4% in 2007. The age group 20-44 showed a moderate increase from 5.6% to 12.4%. //2010//***

**Health Status Indicators 05B:** *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

| Annual Objective and Performance Data | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|
| Annual Indicator | 3.5 | 4.3 | 9.7 | 8.9 | 12.6 |
| Numerator | 81 | 83 | 188 | 152 | 236 |
| Denominator | 23000 | 19370 | 19370 | 17117 | 18664 |

| | | | | | |
|---|---|---|---|---|---|
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |

**Notes - 2008**
Data provided by VI Family Planning Program FY 2008.

Data provided from DOH STD/HIV/AIDS/TB Prevention Program for FY 2008. Inclusive of all testing sites in the territory.

**Notes - 2007**
Denominator obtained from 2005 VI Household Survey, UVI Eastern Caribbean Center.
Numerator reflects territorial data reported by the DOH STD/TB/HIV/AIDS Program for CY 2007.

**Notes - 2006**
Data obtained from DOH STD/HIV/AIDS/TB Prevention annual report for FY 2006.

**Narrative:**
***/2010/ VIFPP has done the majority of Chlamydia/GC testing ( of 3,321 tests done, 1,295 were done at VIFPP clinics sites). The USVI STD Program does the contact tracing of partners of positive clients from all testing sites. All sites provide basic infertility services at Level I and include an initial interview, education, physical examination, counseling, and appropriate referral. The age group 20-44 showed a moderate increase from 8.9% to 12.4%. //2010//***

**Health Status Indicators 06A:** *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

| **CATEGORY** TOTAL POPULATION BY RACE | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** |
|---|---|---|---|---|---|---|---|---|
| Infants 0 to 1 | 1771 | 356 | 1314 | 0 | 85 | 0 | 0 | 16 |
| Children 1 through 4 | 6823 | 255 | 5362 | 0 | 0 | 0 | 0 | 1206 |
| Children 5 through 9 | 7134 | 217 | 5838 | 0 | 0 | 0 | 0 | 1079 |
| Children 10 through 14 | 8744 | 205 | 7409 | 0 | 0 | 0 | 0 | 1130 |
| Children 15 through 19 | 8534 | 485 | 6970 | 0 | 0 | 0 | 0 | 1079 |
| Children 20 through 24 | 5550 | 102 | 4857 | 0 | 0 | 0 | 0 | 591 |
| Children 0 through 24 | 38556 | 1620 | 31750 | 0 | 85 | 0 | 0 | 5101 |

**Notes - 2010**

**Narrative:**
Infants 0-1 estimated based on calendar year 2007 report from Office for Vital Records & Statistics.
***/2010/ Population data for this indicator obtained from the 2006 VI Community Survey.//2010//***

**Health Status Indicators 06B:** *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

| **CATEGORY** TOTAL POPULATION BY HISPANIC ETHNICITY | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** |
|---|---|---|---|
| Infants 0 to 1 | 1375 | 323 | 73 |
| Children 1 through 4 | 5206 | 1618 | 0 |
| Children 5 through 9 | 5488 | 1642 | 0 |
| Children 10 through 14 | 6973 | 897 | 0 |
| Children 15 through 19 | 6943 | 1591 | 0 |
| Children 20 through 24 | 4422 | 1128 | 0 |
| Children 0 through 24 | 30407 | 7199 | 73 |

**Notes - 2010**

**Narrative:**
Younger or older mothers, and mothers belonging to racial and/or ethnicity minority groups may be at increased risk of adverse maternal outcomes. Identifying populations of women and their infants at risk, and implementing coordinated systems of pre-conceptual/perinatal services that assures receipt of risk-appropriate health care delivery is essential for healthy mothers and babies.
***/2010/ Due to the time required to receive certificates of live births and thoroughly edit files, the final live birth data for 2008 is not yet available, and may not be available until late fall 2009. Previous experience has shown that preliminary vital statistics estimates made at this time of year (the June after the reporting year) are often inexact. Therefore, vital statistics numbers for 2008 are not used in this narrative. Final data for CY 2007 is provided. //2010//***

**Health Status Indicators 07A:** *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

| **CATEGORY** Total live births | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** |
|---|---|---|---|---|---|---|---|---|
| Women < 15 | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 0 |
| Women 15 | 60 | 16 | 44 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| through 17 | | | | | | | | |
| Women 18 through 19 | 166 | 42 | 117 | 0 | 6 | 0 | 0 | 1 |
| Women 20 through 34 | 1293 | 252 | 963 | 0 | 63 | 0 | 0 | 15 |
| Women 35 or older | 250 | 46 | 188 | 0 | 16 | 0 | 0 | 0 |
| Women of all ages | 1771 | 356 | 1314 | 0 | 85 | 0 | 0 | 16 |

**Notes - 2010**

**Narrative:**
The greatest racial and ethnic disparities are seen in the following causes of death in infants: disorders relating to pre-term birth and unspecified low birth weight; respiratory distress syndrome; infections specific to the perinatal period; complications of pregnancy; and sudden infant death syndrome (SIDS). In some American Indian/Alaskan Native populations, the incidence of SIDS is three times that of white populations. African American adolescent males have the highest homicide rates in the country. Suicide among adolescent males in certain American Indian/Alaskan Native tribes has reached epidemic proportions. Identifying at-risk populations and implementing and monitoring prevention/intervention programs will play an integral role in eliminating disparities in mortality.

**Health Status Indicators 07B:** *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

| **CATEGORY** Total live births | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** |
|---|---|---|---|
| Women < 15 | 0 | 1 | 1 |
| Women 15 through 17 | 43 | 15 | 2 |
| Women 18 through 19 | 107 | 50 | 9 |
| Women 20 through 34 | 1013 | 226 | 54 |
| Women 35 or older | 212 | 31 | 7 |
| Women of all ages | 1375 | 323 | 73 |

**Notes - 2010**

**Narrative:**
Adverse health outcomes disproportionately affect infants and children in foster care or in single parent homes. In 1995, 14 million infants and children aged 0 through 18 years lived below the Federal poverty level; 59 percent of these families were single parent families. Leaving high school before graduation can lead to continued poverty and a higher incidence of juvenile arrests. Many infants and children eligible for Medicaid and other State programs are not enrolled. Data linkage of State program files with Medicaid may identify factors associated with State program eligibility without full participation.

**Health Status Indicators 08A:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

| **CATEGORY** Total deaths | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** |
|---|---|---|---|---|---|---|---|---|
| Infants 0 to 1 | 12 | 0 | 12 | 0 | 0 | 0 | 0 | 0 |
| Children 1 through 4 | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 0 |
| Children 5 through 9 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Children 10 through 14 | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 0 |
| Children 15 through 19 | 9 | 0 | 9 | 0 | 0 | 0 | 0 | 0 |
| Children 20 through 24 | 16 | 4 | 12 | 0 | 0 | 0 | 0 | 0 |
| Children 0 through 24 | 41 | 4 | 37 | 0 | 0 | 0 | 0 | 0 |

**Notes - 2010**

**Narrative:**
The greatest racial and ethnic disparities are seen in the following causes of death in infants: disorders relating to pre-term birth and unspecified low birth weight; respiratory distress syndrome; infections specific to the perinatal period; complications of pregnancy; and sudden infant death syndrome (SIDS).

***/2010/ Identifying at risk populations and implementing and monitoring prevention/intervention programs will play an integral role in eliminating diparities in mortality.***
***Death certificate data for this population is not readily available; additionally, the causes of death are not readily available. //2010//***

**Health Status Indicators 08B:** *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

| **CATEGORY** Total deaths | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** |
|---|---|---|---|
| Infants 0 to 1 | 12 | 0 | 0 |
| Children 1 through 4 | 2 | 0 | 0 |
| Children 5 through 9 | 0 | 0 | 0 |
| Children 10 through 14 | 2 | 0 | 0 |
| Children 15 through 19 | 9 | 0 | 0 |
| Children 20 through 24 | 15 | 1 | 0 |

| | | | |
|---|---|---|---|
| Children 0 through 24 | 40 | 1 | 0 |

**Notes - 2010**

**Narrative:**
***/2010/ All population data for children 1-24 obtained from the 2006 VI Community Survey. //2010//***

**Health Status Indicators 09A:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

| **CATEGORY** Misc Data BY RACE | **Total All Races** | **White** | **Black or African American** | **American Indian or Native Alaskan** | **Asian** | **Native Hawaiian or Other Pacific Islander** | **More than one race reported** | **Other and Unknown** | **Specific Reporting Year** |
|---|---|---|---|---|---|---|---|---|---|
| All children 0 through 19 | 31231 | 1162 | 25575 | 0 | 0 | 0 | 0 | 4494 | 2006 |
| Percent in household headed by single parent | 46.7 | 1.2 | 38.7 | 0.0 | 0.0 | 0.0 | 0.0 | 6.8 | 2008 |
| Percent in TANF (Grant) families | 3.4 | 0.0 | 3.4 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2008 |
| Number enrolled in Medicaid | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2008 |
| Number enrolled in SCHIP | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2008 |
| Number living in foster home care | 101 | 0 | 101 | 0 | 0 | 0 | 0 | 0 | 2006 |
| Number enrolled in food stamp program | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2008 |
| Number enrolled in WIC | 5504 | 116 | 5278 | 0 | 0 | 28 | 66 | 16 | 2007 |
| Rate (per 100,000) of juvenile crime arrests | 1794.0 | 0.0 | 1794.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2008 |
| Percentage of high school drop-outs (grade 9 through 12) | 9.0 | 1.0 | 6.8 | 0.2 | 0.0 | 0.0 | 0.0 | 1.0 | 2007 |

**Notes - 2010**
Data obtained from DHS for CY 2008. Reported for January - June 2008.

Data obtained from DHS for CY 2008. Reported for January - June 2008.

Data on this HSI is not collected or reported by DOH Bureau of Health Insurance and Medical Assistance.

See discussion under related HSCI & HSI measures

Data on this HSI is not collected or reported by DOH Bureau of Health Insurance and Medical Assistance.

See discussion under related HSCI & HSI measures

Data not available from DHS.

Data source PedNSS - VI WIC Program for calendar year 2007.

Data resource VI Police Department, Office of Planning, Research & Development. Rate is based on 310 arrests in this age group for FY 2008. 38.7% of these were categorized as violent crimes.

**Narrative:**
Adverse health outcomes disproportionately affect infants and children in foster care or in single parent homes. In 1995, 14 million infants and children aged 0 through 18 years lived below the Federal poverty level; 59 percent of these families were single parent families. Leaving high school before graduation can lead to continued poverty and a higher incidence of juvenile arrests. Many infants and children eligible for Medicaid and other State programs are not enrolled. Data linkage of State program files with Medicaid may identify factors associated with State program eligibility without full participation.

**Health Status Indicators 09B:** *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

| **CATEGORY** Miscellaneous Data BY HISPANIC ETHNICITY | **Total NOT Hispanic or Latino** | **Total Hispanic or Latino** | **Ethnicity Not Reported** | **Specific Reporting Year** |
|---|---|---|---|---|
| All children 0 through 19 | 21088 | 6648 | 3495 | 2006 |
| Percent in household headed by single parent | 39.9 | 6.8 | 0.0 | 2008 |
| Percent in TANF (Grant) families | 3.4 | 0.0 | 0.0 | 2008 |
| Number enrolled in Medicaid | 0 | 0 | 0 | 2008 |
| Number enrolled in SCHIP | 0 | 0 | 0 | 2008 |
| Number living in foster home care | 0 | 0 | 0 | 2008 |
| Number enrolled in food stamp program | 0 | 0 | 0 | 2008 |
| Number enrolled in WIC | 4293 | 1200 | 16 | 2007 |
| Rate (per 100,000) of juvenile crime arrests | 1794.0 | 0.0 | 0.0 | 2008 |
| Percentage of high school drop-outs (grade 9 through 12) | 99.0 | 1.0 | 0.0 | 2007 |

**Notes - 2010**

Data on this HSI is not collected or reported by DOH Bureau of Health Insurance and Medical Assistance.

See discussion under related HSCI & HSI measures

Data on this HSI is not collected or reported by DOH Bureau of Health Insurance and Medical Assistance.

See discussion under related HSCI & HSI measures

Data not available from the Department of Human Services.

Data not available from the Department of Human Services.

**Narrative:**
Adverse health outcomes disproportionately affect infants and children in foster care or in single parent homes. In 1995, 14 million infants and children aged 0 through 18 years lived below the Federal poverty level; 59 percent of these families were single parent families. Leaving high school before graduation can lead to continued poverty and a higher incidence of juvenile arrests. Many infants and children eligible for Medicaid and other State programs are not enrolled. Data linkage of State program files with Medicaid may identify factors associated with State program eligibility without full participation.

**Health Status Indicators 10:** *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

| Geographic Living Area | Total |
|---|---|
| Living in metropolitan areas | 0 |
| Living in urban areas | 17000 |
| Living in rural areas | 17556 |
| Living in frontier areas | 0 |
| **Total** - all children 0 through 19 | 34556 |

**Notes - 2010**

**Narrative:**
Child health outcomes and the patterns of utilization of health care services can differ greatly by geographic area of living. Poor families living in metropolitan and urban areas without a regular source of coordinated health services may over utilize emergency services or present as frequent walk-ins to community or public health clinics. Access to care for the poor and under-served in rural and frontier areas is largely dependent on the number of providers available and willing to see the uninsured or accept Medicaid or CHIP. Barriers to quality health care may also include inadequate transport to care and ill-equipped health care facilities.
***/2010/ This data is not collected by the VI Community Survey Therefore, Census 2000 data is used. //2010//***

**Health Status Indicators 11:** *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

| Poverty Levels | Total |
|---|---|
| Total Population | 113689.0 |
| Percent Below: 50% of poverty | 17.2 |
| 100% of poverty | 23.0 |
| 200% of poverty | 48.0 |

**Notes - 2010**

**Narrative:**
Eligibility for Medicaid, SCHIP and other State programs is in part determined by family income as a percentage of federally defined poverty levels. States have some discretion in determining which groups their Medicaid and SCHIP programs will cover and the financial criteria for Medicaid and SCHIP eligibility.

**Health Status Indicators 12:** *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

| Poverty Levels | Total |
|---|---|
| Children 0 through 19 years old | 31231.0 |
| Percent Below: 50% of poverty | 21.7 |
| 100% of poverty | 29.5 |
| 200% of poverty | 70.6 |

**Notes - 2010**

**Narrative:**
Eligibility for Medicaid, SCHIP and other State programs is in part determined by family income as a percentage of federally defined poverty levels. States have some discretion in determining which groups their Medicaid and SCHIP programs will cover and the financial criteria for Medicaid and SCHIP eligibility.

## F. Other Program Activities

Basic CPR training was provided for all front-line staff by EMS instructors. Nursing and medical staff received CPR recertification based on their level of training.
The University of Miami Miller School of Medicine - Center for Medical Genetics provided a workshop on both islands on expanded newborn screening in the VI. The workshop was attended by all MCH clinical and medical staff, hospital and laboratory staff and other interested individuals. The overall goal is to develop and implement a newborn screening educational and resource availability program for the VI and Puerto Rico. Critical to the success of this project is the collection of data through interviews, assessments and observations. This data will provide the basis for identifying barriers as well developing policy and implementing changes.
Nursing and administrative staff on both islands attended MCHB Leadership Skills Institutes - Planning, Implementation and Evaluation Programs; and Systems.
/2009/ Basic Fire Safety training was provided for all staff in both districts.
C.A.R.E.S. (Courteous Accessible Respectful Equal Service), a customer service skills program

was developed to provide MCH & CSHCN program staff training to evaluate and improve customer service skills by introducing practical and sustainable behaviors to develop quality service and performance standards that produce effective skills in communication, listening, conflict resolution and team building. The overall goal was to improve service perceptions of families accessing services at the MCH Program, improve client/patient relations and communications and improve customer service performance standards.
TA was approved by MCHB to develop and conduct training in Continuous Quality Improvement (CQI) for all staff / personnel. The purpose is to provide assistance and training needed to improve ability for effectively building organizational and system capacity required for implementation of the Title V Block Grant; assist in development of MCH Strategic Plan; improve infrastructure building services related to program planning, evaluation, quality assurance and integrated system of care; improve ability to process and plan for MCH Needs Assessment; and promote the need for objective data to analyze and improve program activities and processes. Two of three sessions have been completed at the time of this report. The final session of this initial training is anticipated to be completed by September 2008.
Program Director attended a 2-day training sponsored by the MCHB/HRSA-funded State Adolescent Health Resource Center. This training which was part orientation, part training, part technical assistance, the Orientation Action Lab offers new state adolescent health coordinators a chance to: assess role in addressing adolescent health in state systems from a public health perspective; identify resources to support state-level adolescent health work; build partnerships and connections; apply healthy youth development as a best practice to adolescent health prevention and promotion efforts; and communicating strategically to build support for adolescent health, internally and externally. The training goal is to inspire and improve action planning by offering best practices and applied knowledge about adolescent health.
Program Director and MCH Clinic RN (STT) attended the Building State Systems for Fetal Alcohol Spectrum Disorders sponsored by HRSA/SAMHSA- FASD Center for Excellence and Center for Substance Abuse Prevention and. The goal of this meeting is to ensure that the Title V Director and clinical staff have the skills necessary to address various issues about the lack of collaboration between systems serving individuals with FASD, and the need to increase state involvement in preventing and treating FASD. In addition, identification, management and treatment of FASD is being addressed in the MOU between MCH and the VI DOH Division of Mental Health/Substance Abuse and Drug Dependency Services that is currently under discussion.
Program Director attended a Puerto Rico State Leadership Workshop for Improving EPSDT: Advancing a Collaborative Action Agenda to Improve Child Health, co-sponsored by HRSA/MCHB. The purpose was to provide an opportunity to discuss important and emerging topics related to child health. The outcome of these discussions is to assure that children served by Medicaid and EPSDT receive optimal quality health care with appropriate screening, diagnosis and treatment. //2009//

/2010/ Since the return of the DOH Nutritionist to the program in 2008, referrals to her have increased for evaluation children who are obese or at-risk. In view of the increasing number of referrals, she has made several presentations to the children during clinic hours on healthy food choices. New brochures on healthy food choices for various ages and posters were placed in the clinic regarding healthy foods. As part of the anticipatory guidance counseling that that nurses do, they have been emphasizing healthy food choices. The nurses have also done several presentations on good nutrition in private counseling with their patients who have juvenile diabetes, in accordance with the American Diabetic Association standards.
Three of the LEADD participants at MCH are working in collaboration on an obesity project. One participant is attempting to collect data on the actual number of children that are seen in the MCH clinics on St. Thomas and St. John who meet the criteria of obesity according to the CDC BMI standards. The other participant is working on developing a parental survey that looks at parental perception of their child's weight status to determine whether or not parents accurately perceive their child's weight status in order to determine if parental misperception plays a significant role in the childhood obesity problem that seems to exist here in the Virgin Islands. The third participant is looking at ways to implement the WE CAN (Ways to Enhance Children's

Activity and Nutrition) program. "We Can" is a national program designed for families and communities to help children maintain a healthy weight. The programs focuses on three important behaviors: improved food choices, increased physical activity and reduce screen time. Data collected will be used to develop a comprehensive program to address the problem of childhood obesity. The program recently purchased a scale (St. Thomas) that accurately calculates body mass index (BMI) by entering height and weight at the request of the nursing staff. This is now done routinely on all children presenting to the clinic as part of vital signs measurement.

Continuing Education

Staff attended conferences presented by the Westchester Institute for Human Development in association with the New York Medical College and in partnership with the VI University Center for Excellence in Developmental Disabilities.

- March 2009. Health Care Disparities, Culture and Cross-Cultural Communication in the Setting of Children and Families; A Continuing Education Conference for Professionals Working with Children with Special Health Care Needs and their Families. Purpose: To increase awareness among health care professionals of racial and ethnic health care disparities among children and the specific roles played by providers and language and to promote an understanding of the roles of cultural beliefs and practices in an individual's approach to health, illness, and health care.
- December 2008. Emergency Preparedness for Children and Adults With Special Needs. Purpose: To assist health professionals to care for patients and clients in the event of an emergency.

We are first responders in disaster management and have been doing extensive training in preparation to natural disasters, environmental health hazards and epidemics/pandemics of infectious diseases. We have organized a response team, stocked up on inventory, and have begun preparing protocols for the management of various incidents. With the pandemic H1N1 flu virus, the staff prepared brochures and handouts for parents and increased education on preventative measures and good hygiene practices. The clinic was stocked with kits for testing individuals, and everyone was trained on the proper use of the kits. Protective gear for the staff was administered. A protocol of management for anyone suspicious of being infected was put in place.

## G. Technical Assistance

Technical Assistance [Section 509 (a)(4)]

Technical assistance is of immeasurable value in ensuring the systematic, comprehensive, and valid public health approach to needs assessment, information systems development, general systems development, and special issues.

New and emerging issues in the delivery of health care to the maternal and child health population demand on-going staff training and education in order to continue to provide current and adequate comprehensive, culturally competent services.

The geographical location of the territory and the high costs of travel to the mainland are barriers to travel for training. Reassessment of staff training needs dictate that technical assistance training in the identified areas should be offered within the territory in order to maximize the benefits obtained.

See the complete Form 15 for the V.I. Technical Assistance request for FY 2005.

/2009/ Access to vital statistics that can be tracked, analyzed, and reportable for infants, children, adolescents, and women in the age groups specified in the majority of National and State Measures.

VI-MCH/CSHCN is at an impasse on the historical issue of "lack of effective data". Despite futile efforts through verbal and written communicate on the importance of qualifiable data, the responses year-to-year are deficient. Therefore, TA is requested to allocate special funding to execute an annual contract for professional service with the University of the Virgin Islands Eastern Caribbean Research Center, a well-recognized, systemic entity that delivers annual statistics on Housing and Community demographics. The University's data has sustained the VI-MCH/CSHCN needs over the past 5 years in being able to report on key population-based data.

The engagement of this entity would remedy at least 90% or more of our concerns for invalid, obsolete data.

Integrate national statistical that can be compared to local performance measures

TA to develop and implement a dedicated Health Systems Capacity database that is interlinked to specific National Performance Measures, e.g., #6, #10 and #16.

Augment the implementation of a comprehensive Adolescent Healthcare system through collaboration with national program with success and best practices history

Compose a representative team of at least 3 members of the MCH/CSHCN Advisory Board and program management to visit an accomplished MCH adolescent program. TA will help further the support for start-up of the VI adolescent service program. The intent is to conduct a demonstration (collaborative) program of six months to one year, in a select location, such a local high school where services will be administered in it entirety. TA will support the framework in which this endeavor will occur.

Overall, it is difficult to develop and implement a sound plan of action that involved access to integrated data on the population MCH/CSHCN serves. This is especially true because the vast majority of statistical data is managed by a broad field of inter and intra-agency sources, and there is formal infrastructure that guides access to State data. Therefore, we have no choice but to seek rapid, alternative measures to alleviate the hardship of acquiring that mandatory, vital information.

Through this request for TA, the VI MCH/CSHCN desire is to collaborate with other National program affiliates to share their methodology and to work through challenges. //2009//

# V. Budget Narrative

## A. Expenditures

The request for federal funds is based on OBRA-89 regulations and program priorities. Emphasis is placed on allocating resources to ensure service availability, operational capacity, and the achievement of positive health outcomes. Specific allocations were made to support comprehensive program development and obtain needed personnel to implement the annual plan. This was done within restrictions of the Government of the Virgin Islands budgetary, financial, accounting, procurement, and personnel system. The MCH & CSHCN Program is guided by such government regulations and policies.

The budget for the Maternal Child Health Block Grant was developed by the Program Director and Territorial Financial Management Coordinator. Specific estimates were requested of program staff responsible for implementing new initiatives. The process of deriving budget estimates was based on the previous fiscal year's actual expenditures and forecasted costs based on the program plan and proposed activities. Due to the assurance role of the MCH & CSHCN Program, funds must be kept available to cover patient care costs. The Title V guideline for the use of funds was adhered to. (Please see Form 2, Form 3, Form 4, and Form 5). Estimates are used in providing budget and expenditure details using actual costs for direct services provision including personnel providing services to children with special needs and subspecialty contracts.

## B. Budget

Federal funding through the Title V MCH Block Grant provides needed support to program efforts. There is no continuation funding for special projects in fiscal year 2009. Title V funding has decreased by 9% over the past three fiscal years. This status is not expected to change in the near future. An anticipated increase in the state match is budgeted to cover increases negotiated between the local government and employee unions.

The Virgin Islands Department of Health is budgeting a total of $3,055,630 for FY2009. These funds are broken down as follows:

| | Amount | Percent |
|---|---|---|
| Federal Title V | $1,533,492 | 50.0% |
| State | $1,522,138 | 50.0% |

There is a 30/30/10 minimum funding requirement for federal funds. A waiver of this requirement is not requested during this budget year. Of the FY2009 federal Title V allocation, the allocations are as follows:

| | |
|---|---|
| Preventative and Primary Care for Children | $460,048 (30%) |
| Federal Title V | $613,397 (40%) |
| Title V Administrative Costs | $153,349 (10%) |

Local matching funds include an additional $100,000 for the leasing of clinic space on St. Thomas. The MCH & CSHCN Program in the V.I. does not receive its program income for operating expenses. Clinic revenues are deposited into the Health Revolving Fund from which a portion is appropriated in the subsequent fiscal year.
The program does not anticipate any increase in Title V funding this fiscal year. With the anticipated reduction in local funds, the program will remain at or below the same funding levels of previous fiscal years.
Program income from third party payors is not allocated back to the program for provision of

services to children with special health care needs, expansion of family support and outreach services, or operating expenses. This income would enable the program's ability to plan activities that will address national and state performance measures outcomes.
Funds will pay for personnel costs attributable to program administration for the federally budgeted positions of MCH & CSHCN Program Director, Assistant Director, and Financial Management Coordinator. These funds will also pay for inter-island travel, training, maintenance of office equipment, administrative office space, and utilities required for the appropriate administration of the program. Funds will be utilized to maintain clean and healthy facilities for all employees and consumers to enter and receive services.

Administrative costs up to ten (10) percent of the federal allocation will be used to support administrative staff salaries, newspaper announcements, travel for required meetings and conferences both inter-island and on the mainland, office and computer supplies, mailing, internet and postage, contractual services that are needed for the regular maintenance of office equipment and AMCHP annual membership dues.

Direct and Enabling Services
Block Grants funds will be used to provide preventive and primary care services to women of reproductive age and their infants up to one year of age, children, and youth. The scope of services includes prenatal and high-risk prenatal care, and postpartum care. These funds will be used to support: employment of required medical and clinic staff; needed services not directly being provided by the program including specialty consultation not available in the territory; equipment and supplies needed by the clinics; outreach activities, and technical assistance for developing a public awareness campaign. Funds will also be used to provide inter-island travel for the Territorial Perinatologist to visit St. Croix on a weekly basis to provide clinical consultation and diagnostic studies such as sonograms and amniocentesis for high-risk prenatal clients.

Funds will be used for provision of services and / or care coordination for children with special health care needs. Clinic services include screening, diagnosis and treatment provided by the following disciplines: pediatrics, nursing, social work, nutrition, audiology, speech pathology, physical and occupational therapy. Funds will be used to support contractual costs to provide on-island specialty clinics in hematology, orthopedics, neurology, cardiology, and off-island services such as endocrinology consultations, and echocardiograms. The program will also pay for those children with special health care needs who may need to travel to Puerto Rico for further medical care not available on island. Hearing aides, wheelchairs, other assistive and orthotic devices may be purchased for patients as payor of last resort after all other resources are explored and exhausted.

Population Based Services
Funds will be used to conduct public awareness and informational projects; to fund staff for outreach programs; public health awareness campaigns and health promotions activities. These activities include immunizations, oral health education, nutrition related activities and injury prevention.
Funds will be used to support the newborn hearing screening program primarily in the form of dedicated staff time to the project, and purchase of supplies required to perform screening. Administrative costs for newborn metabolic / genetic screening will be the responsibility of both hospitals. However, the Title V Program will be responsible for follow-up and counseling for all children identified and diagnosed with an inheritable disorder. Funds will be used to purchase vaccine not available through the Immunization Program for children whose families are insured and not eligible to receive vaccines through the VFC Program. Funds will be set aside to support the Dental Health Program through purchase of sealants and other supplies for eligible children.

Infrastructure Building Services
Funding to support the annual meeting of the V.I. Alliance for Primary Care will be budgeted. Funds will be used to provide staff training and development necessary to ensure compliance with national performance measures. Funds will also be used for needs assessment and related

activities.
Funds will be used for complete assessment of program data capacity and technology requirements in collaboration with State Systems Development Initiative. Funds will also be used to provide technology for staff participation in web-casts and teleconferences related to program activities.

Maintenance of State Effort
The Virgin Islands Department of Health assures that the level of funding for the MCH & CSHCN Program will be maintained at a level at least equal to that provided during FY=89. Such funding will be provided through direct allocation of local funds and the provision of services to the MCH & CSHCN Program by other departmental programs as in-kind contributions. For FY 2008 funds used to support the leasing of space for the MCH Clinics in St. Thomas are not included to meet the maintenance of state level requirement.

Fair Method of Allocating Funds
A fair method for allocation of Title V funds throughout the Territory has been established by the State agency responsible for the administration of MCH & CSHCN Program. Allotment of Title V funds is based on the needs assessment and is calculated according to:
-Population size served and capacity of each island district; measurements of health status indicators and other data;
-Fixed personnel cost associated with maintaining direct service provision on each island in each of the three service components;
-Costs associated with maintaining support for services in all four levels of the pyramid;
-Coordination with other initiatives and funding streams which supplement, but do not supplant, Title V mandates.

Targeting Funds of Mandated Title V Activities

Funds from the Maternal and Child Health Services Block Grant will be used only to carry out the purpose of Title V programs and activities, consistent with Section 508.

Reasonable Proportion of Funds for Section 501 Purposes

A reasonable proportion of funds will be used to carry out the purposes described in Section 501 (a)(1)(A) through (D) of the Social Security Act. The MCH & CSHCN Program provides direct services in each of the related program components. All charges imposed for the provision of health services are pursuant to a public schedule of charges and adjusted to reflect the income, resources, and family size of individuals receiving the services. In determining ability to pay, a sliding fee scale is used based on the 2006 Federal Poverty Income Guidelines. Low income is defined as 200% of the federal poverty level or below.

## VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. Technical Note
Please refer to Section IX of the Guidance.

## X. Appendices and State Supporting documents
### A. Needs Assessment
Please refer to Section II attachments, if provided.

### B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

### C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

### D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.